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## M03 COVERED GROUPS REQUIREMENTS

# CHAPTER M03
# MEDICAID COVERED GROUPS
# SUBCHAPTER 10

# GENERAL RULES & PROCEDURES

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## M03 MEDICAID COVERED GROUPS

## M0310.000 GENERAL RULES & PROCEDURES



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## Appendices

# M0310.000 GENERAL RULES & PROCEDURES

## M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS

**A. Introduction**

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). The CN classification is divided into subclassifications of *categorically needy,* categorically needy non-money payment (CNNMP) and medically indigent (MI). Within some covered groups are several definitions of eligible individuals. The agency must verify the individual meets a definition and a covered group's requirements.

**B. Refugees**

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

**C. Procedure**

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.131 contains the Definitions;
- M0320 contains the detailed policy and procedures for the Categorically Needy Groups;
- M0330 contains the detailed policy and procedures for the Medically Needy Groups.

## M0310.002 LIST OF MEDICAID COVERED GROUPS

**A. Categorically Needy (CN)**

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the CN classification are listed below.

**1. ABD Groups**

a. former Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD) money payment recipients who currently receive Supplemental Security Income (SSI) or Auxiliary Grants (AG).

b. SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.

c. Auxiliary Grants (AG) cash assistance recipients.

**2. F&C Groups**

a. foster care children receiving IV-E money payments;

b. adoption assistance children receiving IV-E money payments.

**B. Categorically Needy Non Money Payment(CNNMP)**

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the CN classification are listed below.

**1. ABD Groups**

a. ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

b. ABD individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

c. ABD individuals who have a protected status:

1) individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.

2) individuals who are former SSI/AG recipients and meet specified requirements.

3) individuals who are widows(ers) and meet specified requirements.

4) individuals who are classified as 1619(b) by Social Security and meet specified requirements.

5) individuals who are adult disabled children and meet specified requirements.

d. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

**2. F&C Groups**

a. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs.

*b.* Children under age 1 born on or after October 1, 1984, to mothers who were eligible for and receiving Medicaid as categorically needy or categorically needy non-money payment at the time of the child's birth.

*c.* Non-IV-E foster care or Juvenile Justice Department children, or non-IV-E adoption assistance children.

*d.* Individuals under age 21 in an ICF or ICF-MR.

*e.* F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

*f.* F&C individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

**C. Medically Indigent (MI)**

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MI classification are listed below.

**1. ABD Groups**

a. Qualified Medicare Beneficiaries (QMBs).

b. Special Low-income Medicare Beneficiaries (SLMBs).

c. Qualified Disabled and Working Individuals (QDWIs).

d. Qualified Individuals (QI) - Group I and Group 2 (QI-1 and QI-2).

e. ABD With Income ≤ 80% Federal Poverty Limit (ABD 80% FPL*)*.

**2. F&C Groups**

a. Pregnant women and newborns under age 1 year.

*b. Family Planning Services.*

*c. Children under age 19 years.*

**3. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

Women screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

**D. Medically Needy (MN)**

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MN classification are listed below.

**1. ABD Groups**

a. Aged - age 65 years or older.

b. Blind - meets the blind definition

c. Disabled - meets the disability definition.

d. Individuals who received Medicaid in December 1973 as AB/APTD-related medically needy and who continue to meet the December 1973 eligibility requirements.

**2. F&C Groups**

a. Children under age 18.

b. Children under age 1.

c. Pregnant Women.

d. Non-IV-E Foster Care/Adoption Assistance children and Juvenile Justice Department children.

e. Individuals under age 21 in an ICF or ICF-MR.

**E. Refugees**

"Refugees" are a special group of individuals who have an alien status of "refugee", and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

There are two PDs for this group. PD 78 is used for Refugee Other and Refugee Medicaid Other and PD 79 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

## M0310.100 DEFINITION OF TERMS

**A. Introduction**

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

## M0310.101 ABD

**A. ABD Definition**

"ABD" is the short name used to refer to aged, blind or disabled individuals.

**B. Procedures**

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged.
- M0310.106 Blind.
- M0310.112 Disabled.

## M0310.102 ADOPTION ASSISTANCE

**A. Definition**

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive

parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E adoption assistance agreement with a department of social services or in conjunction with a child placing agency.

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

**B. Procedures**

A child under 21 is an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or subsidy payments are not being made.

A child's status as an adoption assistance child is verified by the local agency foster care/adoption assistance worker. Documentation of the child's adoption assistance eligibility must be part of the Medicaid case record.

**1. IV-E Adoption Assistance**

a. The following children meet the IV-E adoption assistance definition:

1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a private child placing agency, who reside in Virginia. Eligibility begins when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are not being made.

2) children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

b. Verification of a child's status as a Virginia IV-E adoption assistance recipient is obtained through the local agency's Service Programs Division.

When the IV-E adoption assistance agreement is with another state and the IV-E child resides in Virginia, verification of the child's status as a Title IV-E adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

**2. Non-IV-E Adoption Assistance**

a. The following children meet the non-IV-E adoption assistance definition:

1) "special medical needs" children legally adopted under a non- IV-E adoption assistance agreement with a Virginia local department of social services, in accordance with policies established by the State Board of Social Services.

2) special medical needs children legally adopted under a non-IV-E adoption assistance agreement with a private, non-profit child placement agency in conjunction with a local department of social services, and in accordance with policies established by the Virginia Board of Social Services.

b. *A child with "special medical needs" is a child who was determined unlikely to be adopted because of:*

- *a physical, mental or emotional condition that existed prior to adoption; or*
- *a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.*

*Medicaid coverage is to be provided to any child who has been determined to be a non-IV-E child with "special medical needs" and for whom there is in effect an adoption assistance agreement between the State and an adoptive parent(s). Verification of the child's status as a "special medical needs" child is obtained from the local agency's service programs division. A copy to the adoption assistance agreement specifying that the child has a special medical need is sufficient documentation; the agreement does NOT need to specify a particular diagnosis or condition.*

c. Verification of a child's status as a *Virginia* non-IV-E adoption assistance recipient is obtained through the local agency's Service Programs Division. Verification of the child's non-IV-E adoption assistance status with another state, and the state's reciprocal agreement under the interstate compact, is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

## M0310.103 AFDC

**A. Aid To Families With Dependent Children (AFDC)**

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997 implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

**B. Procedure**

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

## M0310.104 AG

**A. Auxiliary Grants (AG)**

"AG" is the short name for the Auxiliary Grants Program. AG is Virginia's assistance program that supplements the federal Supplemental Security Income (SSI) assistance program. AG is Virginia's "State Supplementation of SSI." AG is available only to ABD financially eligible individuals who reside in licensed Adult Care Residences (ACRs).

**B. Procedure**

Check the local agency records of AG recipients. If the individual is eligible for and receiving an AG payment, he/she is an AG recipient for Medicaid purposes.

## M0310.105 AGE and AGED

**A. Age**

"Age" is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

Eligibility in a Medicaid covered group often depends on an individual's age.

**B. Aged**

"Aged," means age 65 years or older.

**C. Procedures**

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

## M0310.106 BLIND

**A. Definition**

*Blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye.*

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

**B. Procedures**

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Individuals who meet the visual eligibility are certified by the Department for the Blind and Vision Impaired (DBVI) and are listed in the Virginia Registry of the Blind. Call DBVI at 1-800-622-2155 to verify that an individual has been certified as blind.

*An individual who requires a determination of blindness must be referred to the Disability Determination Services (DDS) using the procedure in M0310.112 E. 1.*

# M0310.107 CARETAKER-RELATIVE

## A. Definitions

**1. Caretaker-relative**

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

**2. Specified Degree**

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

## B. Procedures

**1. Relationship**

The relationship *as declared on the application/redetermination form is used to determine the* caretaker-*relative's relationship to the child. No verification is required.*

***2. Living in the Home***

*A child's presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.*

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# M0310.108 CATEGORICALLY NEEDY (CN & CNNMP)

**A. CN Definition**

"CN" is the short name for "categorically needy." CN is one of the two federal classifications of Medicaid covered groups. The CN covered groups in Virginia include the mandatory cash assistance categorically needy groups listed in the federal Medicaid regulations. "Mandatory" groups are groups of individuals that a state's Medicaid state plan must cover.

A categorically needy (CN) individual is one who is eligible for and usually receiving some type of cash assistance (money payment), or is deemed to be a cash assistance recipient, and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

**B. CNNMP Definition**

"CNNMP" is the short name for "categorically needy non money payment." CNNMP is the name Virginia uses for the federal "optional" categorically needy covered groups and the mandatory categorically needy covered groups that do not receive cash assistance. "Optional" means the state can choose whether or not to cover a particular group of individuals in its state plan.

A CNNMP individual is one who is not receiving a cash assistance money payment and is usually not eligible for cash assistance, but who meets the requirements of a CNNMP covered group and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

**C. Procedures**

See subchapter M0320 for the policy and procedures to use to determine if an individual meets a categorically needy or CNNMP covered group.

## M0310.109 COVERED GROUP

**A. Definition**

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

**B. Procedure**

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

## M0310.110 CHILD

**A. Definition**

An individual under age 21 years who has not been legally emancipated from his/her parent(s) is a child.

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

## M0310.111 DEPENDENT CHILD

**A. Definition**

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a needy child who is:

1. under the **age of 18**, or under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in *a General Educational Development (GED) program* IF he may be reasonably expected to *complete the secondary school, training or program* before he attains age 19; and

2. **living *in the home of a parent* or *a caretaker*-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. *See section M0310.107 for the definition of a caretaker-relative.*

**B. Age & School Enrollment**

**1. Age**

*The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.*

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency AND is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

**2. School Enrollment**

*Accept the declaration of school enrollment.*

**C. *Living With a Parent or Caretaker-Relative***

**1. Relationship**

*The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.*

*For the purpose of determining a relationship, neither death, divorce, nor adoption terminates relationship to the biological relatives.*

**2. Living in the Home**

*A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required.*

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or non-medical (residential) institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Long-term care rules do not apply to children in residential treatment facilities.

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# M0310.112 DISABLED

**A. Introduction**

The Social Security Administration (SSA) defines disability for an individual who is age 18 or older as the inability to do any substantial gainful activity (work) because of a severe, medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 continuous months, or which is expected to result in death.

SSA defines disability for a child under age 18 as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. However, a child cannot be found disabled if, at application, the child is performing substantial gainful activity and is not currently entitled to SSI benefits.

The Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making the determinations of medical eligibility for disability or blindness benefits under Social Security (SS), Supplemental Security Income (SSI), and Medicaid. DDS works in partnership with the SSA, the Department of Medical Assistance Services (DMAS), and the Department of Social Services (DSS) in processing disability and blindness claims and makes its determinations of "disabled" or "not disabled" based upon federal regulations. The same definitions of disability and blindness and the same evaluation criteria are used for all three programs.

The Railroad Retirement Board (RRB) makes disability determinations for railroad employees. "Total" disability determinations mean the individual is disabled for all regular work. "Occupational" disability means the individual is disabled for regular railroad occupation, but not "totally" disabled. Individuals who receive a "total" disability determination are disabled using the same criteria as the SSA.

The Medicaid disability definition is the same as the SS, SSI, and the Railroad Retirement (RR) total disability definition.

**B. Policy**

Individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination and individuals who have been determined disabled by the RRB meet the Medicaid covered group requirement of being "disabled."

**C. Who Meets the Medicaid Disability Definition**

An individual meets the Medicaid disability definition if he:

- receives SS/SSI as a disabled individual, or RR total disability benefits; or
- has been found to be disabled by the DDS without a subsequent decision by SSA reversing the disability decision.

An applicant who received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason other than no longer meeting the disability or blindness requirement continues to meet the disability or blindness definition.

An applicant who has not received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application must reapply for a disability determination.

**1. Individual Has Been Determined Disabled and receives Benefits From SSA**

If an applicant alleges that he has been found to be disabled and is receiving SS/SSI disability benefits, verify his disability status through a SVES *(State Verification Exchange System)* request or through documentation provided to the applicant by the SSA.

If the individual applies for retroactive coverage and the SSI decision or the SVES SSI information do not specify a disability onset date that covers the Medicaid application's retroactive period, refer the individual to DDS for a disability determination using the procedures in E. 1. below.

**2. Individual Has Been Determined Totally Disabled by RRB**

If an applicant alleges that he has been found to be totally disabled and is receiving RR benefits, verify his disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

**3. Individual Has Been Determined Disabled by DDS**

If the applicant alleges that he has been found to be disabled by the DDS but there is no disability determination on file, verify his status by contacting the DDS at 804-662-9222.

**D. DDS Disability Determinations-General Information**

An individual who is claiming a disabling condition and does not receive SS/SSI disability benefits, or RR total disability benefits and has not been denied disability or has not had disability determined by DDS, must have his disability determined by DDS.

The DDS makes a determination of disability when the:

- applicant alleges a disabling condition and has never applied for a disability from SSA or has not been denied disability within the past 12 months;
- SSA has not made a decision on a pending SS/SSI claim; or
- applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

***1. Hospital Referrals to DDS for Expedited Disability Determination***

*The 2004 Budget Bill mandated DDS make a disability determination within 7 working days of receipt of a referral from DSS when the Medicaid applicant is hospitalized and needs to be transitioned to a rehabilitation facility. To identify those hospitalized individuals who require an expedited disability determination, the following procedures have been established:*

***a. Hospital staff will:***

- *send DSS the Medicaid application and a cover sheet (see Appendix 5 for an example of the cover sheet); and simultaneously*
- *send DDS the medical documentation (disability report, authorizations to release information and medical records) needed to make the disability determination and a copy of the cover sheet.*

***b. DDS must:***

- *make a disability determination within 7 working days; and*
- *fax the result of the disability decision to the DSS.*

***c. DSS must:***

- *fax a completed DDS Referral Form (see Appendix 5 to this subchapter) to DDS at (804) 662-9366, verifying receipt of the Medicaid application;*
- *give priority to processing the applications and immediately request any verifications needed;*
- *process the application as soon as the DDS disability determination and all necessary verifications are received; and*
- *notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.*

*Should DDS be unable to render a decision within 7 working days, DDS will send a communication to the DSS advising that the disability determination has been delayed.*

***2.*** **DSS Referral to DDS Required When Disability Determination Has Not Been Made**

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the DSS to process the application within 90 days, provided all medical information has been submitted. Follow the procedure in E. 1. below for making a referral to DDS *except when a hospital has initiated an expedited disability determination (see D.1. above).*

***3.*** **DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months**

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,

OR

b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND

- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or
- he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

***4.*** **Referral to DDS When SSA Denied Disability More Than 12 Months Ago**

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

## E. DSS Procedures When a Disability Determination is Required

### 1. DSS Referrals to DDS

The following forms must be completed and sent to DDS when *DSS is* requesting a disability determination:

- Disability Report Adult SSA-3368-BK (see Appendix 1 to this subchapter) or the Disability Report Child SSA-3820-BK, (see Appendix 2 to this subchapter) and
- *a minimum of 5 signed, original forms:* Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003 (see Appendix 3 to this subchapter) **or** 1 for each medical provider if more than 5*;* and
- a DDS Referral Form - 032-03-095/05 (see Appendix 4 to this subchapter).

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 days to return the completed forms. When the completed forms are returned, mail them along with the DDS Referral form to:

Disability Determination Services Unit
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

**Do not send referrals to DDS via the courier.**

*The eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed as soon as the decision on the disability determination is received.*

If the completed forms are not returned by the applicant within 45 days from the date of application, the applicant does not meet the covered group and the Medicaid application must be denied.

### 2. Application for Other Benefits

Individuals with a work history, or individuals whose disability began prior to reaching age 22 years and whose parent(s) is retired (because of age or disability) or deceased must apply for Social Security or RR benefits as a disabled individual as a nonfinancial requirement of Medicaid eligibility. Refer individuals with a work history to the appropriate SSA Office to apply for benefits. Refer individuals who report a railroad work history to the Railroad Retirement Board (RRB) to apply for benefits. Applicants are not required to apply for SSI benefits.

Do not delay processing the Medicaid application while waiting for the applicant to apply for SSA/RR benefits. However, if the applicant does not apply for SSA/RR benefits within 45 days from the date of the Medicaid application, deny the Medicaid application due to "failure to

apply for benefits (SSA/RR) for which the individual might be entitled" (see M0270). Notify the DDS to stop action on the disability determination.

**F. Communication Between Agency and DDS**

**1. Eligibility Worker Responsibilities**

The eligibility worker must make every effort to provide the DDS with complete and accurate information. Report all changes in address, medical condition, and earnings to the DDS on pending applications.

If the eligibility worker is aware of changes in the applicant's situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

**2. DDS Responsibilities**

The DDS will advise the local agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. *For hospitalized individuals who meet the requirements for an expedited (within 7 working days) disability determination, DDS will fax the outcome of the disability determination decision to the eligibility worker. For all other disability determinations*, DDS will send the eligibility worker a notice to be sent to the applicant advising him of the outcome of his disability determination.

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant directly of the delay and/or the need for additional information. A copy of the DDS's notice to the applicant will be sent to the local agency so the eligibility worker can send a Notice of Action to extend the pending application.

**G. Notice to the Applicant**

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notification of the applicant's disability status and send the client both the DDS's notification of the disability determination and a Notice of Action of the agency's decision on the Medicaid application.

**H. Applicant is Deceased**

When an individual who applies for a disability determination and Medicaid dies or when the applicant is deceased at the time of the Medicaid application, the DDS will determine if the disability requirement for Medicaid eligibility was met. The eligibility worker must immediately notify DDS of the individual's death and provide a copy of the death certificate, if available.

**I. Subsequent SSA or RRB Disability Decisions**

When SSA or the RRB make a disability decision subsequent to the DDS decision which differs from the DDS decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in D. 3. above applies.

**a. SSA/RRB Approval**

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the

*decision is reversed, reevaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, but eligibility as a disabled individual cannot begin prior to the disability onset date.*

***b. SSA Denial, Termination and SSA Appeal***

*If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.*

*If the individual appeals timely (within 60 days from the SSA notification) the SSA disability decision and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further administrative review.*

*The levels of administrative review are in the following order:*

1) *reconsideration,*
2) *the hearing before an administrative law judge (ALJ), and*
3) *the Appeals Council.*

*For example, an individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case. The ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition nor another covered group, his Medicaid coverage must be canceled.*

***c. RRB Denial, Termination and RRB Appeal***

*If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.*

*Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further If the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification*

*that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.*

## M0310.113 EWB

**A. Essential to The Well-Being (EWB)**

EWB is the short name for a person who is "essential to the well-being" of a child in the household. An EWB who is living in the household and who is providing services which are essential to the well-being of the dependent, deprived child(ren) in the household may be eligible for Medicaid in the LIFC covered group, if the individual

- does not meet any other Medicaid covered group, and
- the individual to whom the EWB provides the service(s) is eligible for Medicaid in the CNNMP LIFC covered group. Services which are essential to the well-being of the dependent, deprived child(ren) in the household are listed in item B.

**B. Services Essential to Well-Being**

Services which are essential to the well-being of the dependent, deprived child(ren) in the household are limited to:

- provision of care for an incapacitated family member in the home;
- provision of child care which enables the caretaker to work on a full-time basis outside the home;
- provision of child care which enables the caretaker to receive training full-time;
- provision of child care which enables the caretaker to attend high school or GED classes full-time;
- provision of child care for a period not to exceed 2 months to enable the caretaker to participate in employment search.

**C. Procedure**

Section M0320.306 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

## M0310.114 FAMILIES & CHILDREN (F&C)

**A. Families & Children (F&C)**

"Families & Children (F&C)" is the group of individuals that consists of

- eligible members of families with dependent children,
- pregnant women, and
- specified subgroups of children under age 21.

**B. Procedures**

See the following sections for definitions of F&C individuals and families:

- M0310.102 Adoption Assistance,
- M0310.107 Caretaker-relative,
- M0310.110 Child,
- M0310.111 Dependent Child,
- M0310.113 EWB,
- M0310.115 Foster Care,
- M0310.118 LIFC,
- M0310.123 Parent,
- M0310.124 Pregnant Woman
- *M0310.133 BCCPTA*

## M0310.115 FOSTER CARE

**A. Definition**

Foster Care provides maintenance and care for children whose custody is held by:

1. a local board of social services;
2. a licensed private, non-profit child placement agency;
3. the Department of Juvenile Justice; or
4. the child's parent(s), under a non-custodial agreement with the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT).

**1. Custody**

Custody may be given either by the court or through a voluntary entrustment by the parent(s).

**2. Child Placing Agency**

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

**3. Non-custodial Agreement**

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services or the public agency designated by the Community Policy & Management Team (CPMT). The parent(s) or guardian retain legal custody of the child. The social services agency agrees to provide financial assistance and services to the child, such as placement in and payment for residential facility services.

Because the agency is assuming partial financial responsibility for the child, the child meets the foster care definition. However, the agency does not have legal custody of the child; therefore, the parent(s) or guardian must apply for Medicaid for the child.

**B. Procedures**

**1. IV-E Foster Care**

Children in the custody of a Virginia local department of social services who are eligible for Title IV-E (AFDC-FC) foster care maintenance payments and who reside in Virginia are IV-E foster care for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for Title IV-E foster care maintenance payments and who now reside in Virginia, are IV-E foster care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

**2. Non IV-E Foster Care**

Children in the custody of a Virginia local department of social services or a private child placing agency who are eligible for non IV-E (state/local) foster care maintenance payments and who reside in Virginia are non IV-E foster care for Medicaid eligibility purposes.

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "corrections child." The corrections child who meets the F&C income limit is IV-E foster care for Medicaid eligibility purposes. A corrections child is not eligible for IV-E foster care.

Children in the custody of another state's social services agency who are not IV-E eligible, do NOT meet the Virginia residency requirement for Medicaid (M0230) and are not eligible for Virginia Medicaid.

## M0310.116 HOSPICE

**A. Definition**

"Hospice" is a CNNMP covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility.

**1. Hospice Care**

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

**2. Hospice Program**

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

**B. Procedure**

The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

## M0310.117 INSTITUTION

**A. Definition**

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

**B. Medical Institution (Facility)**

A **medical institution** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

**C. Procedures**

The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

## M0310.118 LIFC

**A. Low Income Families with Children (LIFC)**

Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent, deprived child(ren) living in the home, and whose income is within the Medicaid F&C income limits.

**B. Procedure**

Section M0320.306 contains the detailed requirements for the LIFC covered group.

## M0310.119 MEDICALLY INDIGENT (MI)

**A. Definition**

"MI" is the short name for "medically indigent." MI is the name Virginia uses for the subclassification of federally mandated categorically needy covered groups that do not receive cash assistance and that have income within a percentage of the federal poverty income guidelines.

An MI individual is one who is not eligible for cash assistance, but who meets the requirements of an MI covered group and has income within the specified percentage of the federal poverty limit.

**B. Procedure** The procedures used to determine if an individual meets an MI covered group are in subchpater M0320.

## M0310.120 MEDICALLY NEEDY (MN)

**A. Definition** "MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All medically needy covered groups are optional; the state can choose whether or not to cover medically needy individuals in its state plan. However, if the state chooses to cover medically needy individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as medically needy blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as medically needy.

The medically needy individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. He is not eligible for a cash assistance payment because his income and/or resources exceed the cash assistance limits. Medically needy individuals whose income exceeds the MN income limit may become eligible as MN by incurring medical and/or remedial care expenses to establish eligibility (spenddown).

**B. Procedure** The procedures used to determine if an individual meets a medically needy covered group are in subchapter M0330.

## M0310.121 MEDICARE BENEFICIARY

**A. Definition** A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health **insurance** program and consists of hospital insurance protection (Part A) and medical insurance protection (Part B).

**1. Part A** A person is entitled to Medicare Part A if he/she

a. is age 65 or older and:

- eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
- a qualified railroad retirement beneficiary,
- not eligible for social security or railroad retirement benefits but meets the requirements of a special transitional provision,
- not eligible for social security or railroad retirement benefits but voluntarily enrolls and pays a monthly premium, or

- would be eligible for social security benefits if his/her governmental employment were covered work under the Social Security Act; OR

b. is under age 65, disabled and

- entitled to or deemed entitled to Social Security disability benefits for more than 24 months,
- would be entitled to Social Security disability benefits for more than 24 months if his/her governmental employment were covered work under the Social Security Act,
- under specified circumstances, entitled to railroad retirement benefits because of disability,
- loses his/her entitlement to disability benefits and Medicare Part A solely because he/she is engaging in substantial gainful employment but voluntarily elect to enroll and pay a monthly premium (Premium Hospital Insurance for the Working Disabled); OR

c. is any age and has end-stage renal disease treated by a kidney transplant or a regular course of kidney dialysis and meets the special insured status requirements.

**2. Part B**

A person is eligible to enroll in Medicare Part B if he or she

a. is entitled to premium-free Medicare Part A (hospital insurance) or to Premium Hospital Insurance for the Working Disabled, OR

b. is age 65 or older, a resident of the U.S., and either

- a citizen of the U.S., or
- an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the 5 years immediately prior to the month in which he or she applies for enrollment.

**B. Procedures**

A Medicare beneficiary may be eligible for Medicaid if he/she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. *Four* of the Medicaid covered groups are specifically for Medicare beneficiaries and provide a limited benefit package (covered services) for Medicare beneficiaries who are eligible in one of these groups: Qualified Medicare Beneficiaries (QMBs), Special Low-income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs) and *Qualified Individuals (QI-1 and QI-2)*.

See sections M0320.207, 208 and 209 for the procedures to use to determine if an individual meets a Medicare beneficiary covered group.

## M0310.122 OASDI

**A. Old Age, Survivors & Disability Insurance (OASDI)**

Old Age, Survivors & Disability Insurance (OASDI) is the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

OASDI is sometimes called RSDI - Retirement, Survivors & Disability Insurance. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

**B. Entitlement**

An individual is fully insured if he has at least 1 credit for each calendar year after 1950, or if later, after the year in which he attained age 21, and prior to the year in which he or she attains age 62 or dies or becomes disabled, whichever occurs earlier.

A worker is entitled to retirement insurance benefits if he is at least age 62, is fully insured and files an application for retirement insurance benefits.

A claimant who is the worker's spouse is entitled to spouse's benefits on the worker's record if the claimant is age 62 or over, has in care a child under age 16 or disabled who is entitled to benefits on the worker's record, and the claimant has been married to the worker for at least 1 year before filing the claim or the claimant is the natural mother or father of the worker's biological child.

A child is entitled to child's insurance benefits on a parent's work record if an application for child's benefits is filed, the child is or was dependent on the parent, the child is unmarried, the child is under age 18 or is age 18-19 and a full-time elementary or secondary school student or age 18 or over and under a disability which began before the child attained age 22; and the parent is entitled to retirement or disability insurance benefits, or died and was either fully or currently insured at the time of death.

When an insured worker dies, monthly cash benefits may be paid to eligible survivors as follows: widow(er)'s benefits, surviving child's benefits, mother's or father's benefits, and parent's benefits.

**C. Procedures**

Verify an individual's entitlement to OASDI by inquiring the MMIS computer system or entering the required data into the State Verification Exchange System (SVES). The individual's award letter from SSA is acceptable verification of OASDI entitlement

## M0310.123 PARENT

**A. Definition**

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

The presence in the home of a "substitute parent" or "man in the house" is not an acceptable basis for a finding of no deprivation. If a man not married to the mother is living in the home, he is the parent (the acknowledged father) when:

- the man has been found by a court to be the child's father.
- the man has admitted paternity either before a court, or voluntarily in writing, under oath.
- the man's name appears on the child's birth certificate issued by the Virginia Department of Health Bureau of Vital Statistics.
- the child has been placed by a court with the man or a relative of the man on the basis that his is the child's father.

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

**B. Procedure**

Section M0320.306 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

## M0310.124 PREGNANT WOMAN

**A. Definition**

A woman of any age who is medically determined to be pregnant meets the definition of a pregnant woman.

**1. Effective Date**

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of "pregnant woman" is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

**Example #3:** a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he "treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date." Therefore, her pregnancy is medically verified

for February - April 1997, since the doctor's statement verifies that she was pregnant in February, March, April, and May.

**B. Procedures**

**1. Verification**

Pregnancy must be medically verified. *Acceptable verification is a certificate or written statement from a physician, public health nurse, or similar medical practitioner which includes an estimated delivery date. If retroactive converge is requested the statement must also include an estimated month of conception since the pregnant woman definition is not met in any month prior to the conception month.*

If the medical practitioner cannot or will not give an estimated month *of conception*, the practitioner's certification that the woman was and is pregnant in the specific months for which Medicaid coverage is requested will suffice as pregnant woman definition verification.

Proof of the birth of a child to the mother is sufficient verification of the mother's pregnancy in the three months prior to the child's birth month.

**2. Covered Groups Eligibility**

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Two of the Medicaid covered groups are specifically for pregnant women: MI Pregnant Women and MN Pregnant Women.

See section M0320.301 for the MI pregnant woman covered group requirements, and section M0330.301 for the MN pregnant woman covered group requirements.

## M0310.125 QDWI

**A. Qualified Disabled & Working Individuals (QDWI)**

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

**B. Procedure**

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group.

## M0310.126 Qualified Individuals

**A. Qualified Individuals (QI)**

QI-1 *is* the short names used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

**B. Procedure**

Qualified individuals is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section M0320.208 for the procedures to used to determine if an individual meets the QI covered group.

## M0310.127 QMB

**A. Qualified Medicare Beneficiary (QMB)**

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income does not exceed *100%* of the FPL.

**B. Procedure**

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section M0320.206 for the procedures to use to determine if an individual meets the QMB covered group.

## M0310.128 RSDI

**A. Retirement, Survivors & Disability Insurance (RSDI)**

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

**B. Procedure**

RSDI Is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

## M0310.129 SLMB

**A. Special Low- income Medicare Beneficiary (SLMB)**

SLMB is the short name used to designate the Medicaid covered group of "Special Low-income Medicare Beneficiary". A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income exceeds the QMB income limit *(100% of the FPL)* but does NOT exceed the higher SLMB income limit, which is *120%* of the FPL.

**B. Procedure**

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part B premium. See section M0320.208 for the procedures to use to determine if an individual meets the SLMB covered group.

## M0310.130 SSI

**A. Supplemental Security Income (SSI)**

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

**B. Procedures**

Individuals who receive SSI (SSI recipients) are not "automatically" eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI's resource requirements. See section M0320.200 for the procedures to use to determine if an SSI recipient meets a covered group.

## M0310.131 STATE PLAN

**A. Definition**

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia's Medicaid program. It contains all the information necessary for the federal *Centers for Medicare and Medicaid Services (CMS)* to determine whether the state plan can be approved for federal financial participation (FFP) in the state's Medicaid program expenses.

**B. State Plan Governs Medicaid Eligibility Rules**

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

## M0310.132 TANF

Temporary Assistance for Needy Families (TANF) is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

## *M0310.134 VIEW PARTICIPANT*

*A Virginia Initiative for Employment not Welfare (VIEW) participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.*

## M0310.133 BCCPTA

**A. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The Breast and Cervical Cancer Prevention and Treatment Act created a Medicaid covered group for women age 40 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

**B. Procedures**

Section M0320.312 contains the detailed requirements for the BCCPTA covered group.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

# DISABILITY REPORT ADULT

**For SSA Use Only**
Do not write in this box.
Related SSN _____
Number Holder _____

## SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

*Area Code* _____ *Number* _____ ☐ Your Number ☐ Message Number ☐ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
*(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)*

_____ _____ _____ DAYTIME PHONE _____ _____
*City* *State* *ZIP* *Area Code* *Number*

E. What is your **height** without shoes? _____ *feet* _____ *inches*

F. What is your **weight** without shoes? _____ *pounds*

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak English**? ☐ YES ☐ NO If "NO," what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? *(If this is the same person as in "D" above show "SAME" here.)*

NAME _____ RELATIONSHIP _____

ADDRESS _____
*(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)*

_____ _____ _____ DAYTIME PHONE _____ _____
*City* *State* *ZIP* *Area Code* *Number*

I. Can you **read English**? ☐ YES ☐ NO J. Can you **write more than your name in English**? ☐ YES ☐ NO

## SECTION 2
## YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain** or other symptoms? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you**? | *Month* | *Day* | *Year* |

E. When did you become **unable to work** because of your illnesses, injuries or conditions? | *Month* | *Day* | *Year* |

F. Have you **ever worked**? ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did **you stop working**? | *Month* | *Day* | *Year* |

J. Why did you **stop working**? _____

## SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **kinds of jobs** that you have had in the **last 15 years that you worked.**

| JOB TITLE *(Example, Cook)* | TYPE OF BUSINESS *(Example, Restaurant)* | DATES WORKED *(month & year)* From | To | HOURS PER DAY | DAYS PER WEEK | RATE OF PAY *(Per hour, day, week,month or year)* | |
|---|---|---|---|---|---|---|---|
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |
| | | | | | | $ | |

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? ____ Stoop? *(Bend down & forward at waist.)* ____ Handle, grab or grasp big objects? ____

Stand? ____ Kneel? *(Bend legs to rest on knees.)* ____ Reach? ____

Sit? ____ Crouch? *(Bend legs & back down & forward.)* ____ Write, type or handle small objects? ____

Climb? ____ Crawl? *(Move on hands & knees.)* ____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

H. Check weight **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (Skip to next page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

## SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

**If you answered "NO" to both of these questions, go to Section 5.**

C. List **other names** you have used on your medical records. _____

_____

**Tell us who may have medical records or other information about your illnesses, injuries or conditions.**

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

| **NAME** | | | DATES |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** | **LAST** SEEN |
| **PHONE** Area Code Phone Number | | **CHART/HMO #** (If known) | NEXT **APPOINTMENT** |
| **REASONS** FOR VISITS | | | |
| WHAT **TREATMENT** WAS RECEIVED? | | | |

2.

| **NAME** | | | DATES |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** | **LAST** SEEN |
| **PHONE** Area Code Phone Number | | **CHART/HMO #** (If known) | NEXT **APPOINTMENT** |
| **REASONS** FOR VISITS | | | |
| WHAT **TREATMENT** WAS RECEIVED? | | | |

## SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

### DOCTOR/HMO/THERAPIST/OTHER

3.

| NAME | | | DATES |
|---|---|---|---|
| STREET ADDRESS | | | FIRST VISIT |
| CITY | STATE | ZIP | LAST SEEN |
| PHONE ____ (Area Code) ____ (Phone Number) | CHART/HMO # (If known) | | NEXT APPOINTMENT |
| REASONS FOR VISITS | | | |
| WHAT TREATMENT WAS RECEIVED? | | | |

**If you need more space, use Remarks, Section 9.**

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1.

| HOSPITAL/CLINIC | | | TYPE OF VISIT | DATES | |
|---|---|---|---|---|---|
| NAME | | | ☐ **INPATIENT** STAYS *(Stayed at least overnight)* | DATE IN | DATE OUT |
| STREET ADDRESS | | | | | |
| CITY | STATE | ZIP | ☐ **OUTPATIENT** VISITS *(Sent home same day)* | DATE FIRST VISIT | DATE LAST VISIT |
| PHONE ____ (Area Code) ____ (Phone Number) | | | ☐ **EMERGENCY ROOM** VISITS | DATE OF VISITS | |

Next **appointment** _____ Your hospital/clinic **number** _____

**Reasons** for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

## SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

### HOSPITAL/CLINIC

2.

| HOSPITAL/CLINIC | | | TYPE OF VISIT | DATES | |
|---|---|---|---|---|---|
| NAME | | | ☐ **INPATIENT** STAYS *(Stayed at least overnight)* | DATE IN | DATE OUT |
| STREET ADDRESS | | | | | |
| CITY | STATE | ZIP | ☐ **OUTPATIENT** VISITS *(Sent home same day)* | DATE FIRST VISIT | DATE LAST VISIT |
| PHONE ____ ____ *Area Code* *Phone Number* | | | ☐ **EMERGENCY ROOM** VISITS | DATE OF VISITS | |

Next **appointment** _____ Your hospital/clinic **number** _____

**Reasons** for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

**If you need more space, use Remarks, Section 9.**

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

| **NAME** | | | **DATES** |
|---|---|---|---|
| **STREET ADDRESS** | | | **FIRST** VISIT |
| **CITY** | **STATE** | **ZIP** | **LAST** SEEN |
| **PHONE** ____ ____ *Area Code* *Phone Number* | | | NEXT APPOINTMENT |
| **CLAIM NUMBER** (If any) | | | |
| **REASONS** FOR VISITS | | | |

**If you need more space, use Remarks, Section 9.**

## SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

| NAME OF MEDICINE | IF PRESCRIBED, GIVE NAME OF DOCTOR | REASON FOR MEDICINE | SIDE EFFECTS YOU HAVE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**If you need more space, use Remarks, Section 9.**

## SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

| KIND OF TEST | WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year) | WHERE DONE? (Name of Facility) | WHO SENT YOU FOR THIS TEST? |
|---|---|---|---|
| EKG (HEART TEST) | | | |
| TREADMILL (EXERCISE TEST) | | | |
| CARDIAC CATHETERIZATION | | | |
| BIOPSY--Name of body part _____ | | | |
| HEARING TEST | | | |
| VISION TEST | | | |
| IQ TESTING | | | |
| EEG (BRAIN WAVE TEST) | | | |
| HIV TEST | | | |
| BLOOD TEST (NOT HIV) | | | |
| BREATHING TEST | | | |
| X-RAY--Name of body part _____ | | | |
| MRI/CT SCAN Name of body part _____ | | | |

**If you have had other tests, list them in Remarks, Section 9.**

## SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: _____

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____
*(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)*

_____
*City* *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

## SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
*(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)*

_____
*City* *State* *Zip*

DAYTIME PHONE NUMBER _____ _____
*Area Code* *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
*(IQ, vision, physicals, hearing, workshops, etc.)*

## SECTION 9 - REMARKS

**Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.**

## SECTION 9 - REMARKS

**ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.**

| Signature of **claimant** or person filing on claimant's behalf ***(parent, guardian)*** | **Date** *(Month, day, year)* |
|---|---|
| | |

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

| 1. Signature of **Witness** | 2. Signature of **Witness** |
|---|---|
| **Address** *(Number and street, city, state, and ZIP code)* | **Address** *(Number and street, city, state, and ZIP code)* |
| | |

# DISABILITY REPORT - ADULT - Form SSA-3368-BK

## PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

### IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at http://www.ssa.gov/disability/3368/.

### HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

### ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

**YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE.** With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

## WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

## The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

**PAPERWORK REDUCTION ACT:** This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 60 minutes to read the instructions, gather the necessary facts, and answer the questions.

**PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.**

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0577

# DISABILITY REPORT - CHILD

## SECTION 1 – INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

**YOUR MAILING ADDRESS** *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY | STATE | ZIP CODE

D. **YOUR DAYTIME PHONE NUMBER** *(If you have no phone number, give us a daytime number where we can leave a message for you.)*

*Area Code* *Number* ☐ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**?

F. Can you **speak English**? YES ☐ NO ☐ If "NO," what languages can you speak?

If you **cannot speak English**, give us the name of someone we may contact who speaks English and will give you messages.

NAME RELATIONSHIP TO CHILD

ADDRESS
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

*City* *State* *ZIP* DAYTIME PHONE *Area Code* *Phone Number*

Can you **read English**? YES ☐ NO ☐

G. Does the child live with you? YES ☐ NO ☐ If "NO," with whom does the child live?

NAME RELATIONSHIP TO CHILD

ADDRESS
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

*City* *State* *ZIP* DAYTIME PHONE *Area Code* *Phone Number*

Can this person **speak English**? YES ☐ NO ☐

If "NO," what languages can this person speak?

Can this person **read English**? YES ☐ NO ☐

## SECTION 1 – INFORMATION ABOUT THE CHILD

H. Can the child speak English? YES ☐ NO ☐

If "NO," what languages can the child speak? _____

I. What is child's height *(without shoes)*? _____ What is child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance card**? (for example, Medicaid, Medi-Cal)

YES ☐ NO ☐

If "YES," show the **number** here: _____

## SECTION 2 – CONTACT INFORMATION

Give the name of a person that we can contact (other than the child's doctors, such as legal guardian) who knows about the child's illnesses, injuries, or conditions and can help you with his/her claim.

NAME OF CONTACT _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____
*Area Code* *Number*

RELATIONSHIP TO CHILD _____

## SECTION 3 – THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**? _____

_____

_____

B. How do the child's illnesses, injuries or conditions **limit his/her daily activities**? _____

_____

_____

C. When did the child become disabled?

| *Month* | *Day* | *Year* |
|---|---|---|
| | | |

D. Do the child's illnesses, injuries or conditions cause **pain**? YES ☐ NO ☐

## SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

YES ☐ NO ☐

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES ☐ NO ☐

**Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.**

C. List **each DOCTOR/HMO/THERAPIST**. Include the child's **next appointment**.

1.

| NAME | | | DATES |
|---|---|---|---|
| STREET ADDRESS | | | FIRST VISIT |
| CITY | STATE | ZIP | LAST SEEN |
| PHONE _____ Area Code _____ Phone Number | | CHART/HMO # | NEXT APPOINTMENT |
| REASONS FOR VISITS _____ | | | |
| WHAT TREATMENT WAS RECEIVED? _____ | | | |

2.

| NAME | | | DATES |
|---|---|---|---|
| STREET ADDRESS | | | FIRST VISIT |
| CITY | STATE | ZIP | LAST SEEN |
| PHONE _____ Area Code _____ Phone Number | | CHART/HMO # | NEXT APPOINTMENT |
| REASONS FOR VISITS _____ | | | |
| WHAT TREATMENT WAS RECEIVED? _____ | | | |

## SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

### DOCTOR/HMO/THERAPIST

3.

| NAME | | DATES |
|---|---|---|
| STREET ADDRESS | | FIRST VISIT |
| CITY STATE ZIP | | LAST SEEN |
| PHONE (Area Code) (Phone Number) | CHART/HMO # | NEXT APPOINTMENT |
| REASONS FOR VISITS | | |
| WHAT TREATMENT WAS RECEIVED? | | |

**If you need more space, use Remarks, Section 10**

D. **List each HOSPITAL/CLINIC.** Include child's **next appointment.**

1.

| HOSPITAL/CLINIC | TYPE OF VISIT | DATES |
|---|---|---|
| NAME | ☐ **INPATIENT** STAYS *(Stayed at least overnight)* | DATE IN / DATE OUT |
| STREET ADDRESS | ☐ **OUTPATIENT** VISITS *(Sent home same day)* | DATE FIRST VISIT / DATE LAST VISIT |
| CITY STATE ZIP | ☐ **EMERGENCY ROOM** VISITS | DATES OF VISITS |
| PHONE (Area Code) (Phone Number) | | |

Next **appointment** _____ The child's hospital/clinic **number** _____

**Reasons** for visits _____

What **treatment** did the child receive? _____

What **doctors** does the child see at this hospital/clinic on a regular basis? _____

## SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

### HOSPITAL/CLINIC

2.

| HOSPITAL/CLINIC | TYPE OF VISIT | DATES |
|---|---|---|
| NAME | ☐ **INPATIENT** STAYS *(Stayed at least overnight)* | DATE IN / DATE OUT |
| STREET ADDRESS | ☐ **OUTPATIENT** VISITS *(Sent home same day)* | DATE FIRST VISIT / DATE LAST VISIT |
| CITY STATE ZIP | ☐ **EMERGENCY ROOM** VISITS | DATES OF VISITS |
| PHONE (Area Code) (Phone Number) | | |

Next **appointment** _____ The child's hospital/clinic **number** _____

**Reasons** for visits _____

What **treatment** did the child receive? _____

What **doctors** does the child see at this hospital/clinic on a regular basis? _____

**If you need more space, use Remarks, Section 10**

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors) or is the child scheduled to see anyone else?

YES ☐ *(If "YES," complete the information below.)* NO ☐

| NAME | DATES |
|---|---|
| ADDRESS | FIRST VISIT |
| CITY STATE ZIP | LAST SEEN |
| PHONE (Area Code) (Phone Number) | NEXT APPOINTMENT |
| CLAIM NUMBER *(If any)* | |
| REASONS FOR VISITS? | |

**If you need more space, use Remarks, Section 10**

## SECTION 5 – MEDICATIONS

Does the child currently take any **medications** for the illnesses, injuries or conditions? YES ☐ NO ☐
If "YES," tell us the following. *(Look at the child's medicine bottles, if necessary.)*

| NAME OF MEDICINE | IF PRESCRIBED, GIVE NAME OF DOCTOR | REASON FOR MEDICINE | SIDE EFFECTS THE CHILD HAS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**If you need more space, use Remarks, Section 10**

## SECTION 6 – TESTS

Has the child had, or will he/she have, any **medical tests** for the illnesses, injuries or conditions?
YES ☐ NO ☐ If "YES," please tell us the following: (give approximate dates, if necessary).

| KIND OF TEST | WHEN DONE, OR WHEN IT WILL BE DONE (Month, day, year) | WHERE DONE (Name of Facility) | WHO SENT THE CHILD FOR THIS TEST |
|---|---|---|---|
| EKG (HEART TEST) | | | |
| TREADMILL (EXERCISE TEST) | | | |
| CARDIAC CATHETERIZATION | | | |
| BIOPSY Name of body part _____ | | | |
| SPEECH/ LANGUAGE | | | |
| HEARING TEST | | | |
| VISION TEST | | | |
| IQ TESTING | | | |
| EEG (BRAIN WAVE TEST) | | | |
| HIV TEST | | | |
| BLOOD TEST (NOT HIV) | | | |
| BREATHING TEST | | | |
| X-RAY Name of body part _____ | | | |
| MRI/CAT SCAN Name of body part _____ | | | |

**If the child has had other tests, list them in Remarks, Section 10.**

## SECTION 7 – ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

| | | |
|---|---|---|
| 1. Headstart (Title V) | YES ☐ | NO ☐ |
| 2. Public or Community Health Department | YES ☐ | NO ☐ |
| 3. Child Welfare or Social Service Agency | YES ☐ | NO ☐ |
| 4. Women, Infant and Children (WIC) Program | YES ☐ | NO ☐ |
| 5. Program for Children with Special Health Care Needs | YES ☐ | NO ☐ |
| 6. Mental Health/Mental Retardation Center | YES ☐ | NO ☐ |
| 7. Vocational Rehabilitation | YES ☐ | NO ☐ |
| If "NO" to 7 above and the child is over age 15, do you want the child to be referred to Vocational Rehabilitation? | YES ☐ | NO ☐ |

If you answered "YES" to any of the above, complete B below.

B. 1. NAME OF AGENCY _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *State* - *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *State* *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

**If there are any other agencies, show them in Remarks, Section 10.**

## SECTION 8 – EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed? _____

B. Is the child currently attending school *(other than summer school)*? YES ☐ NO ☐

If "NO" explain why the child is not attending school. _____

_____

_____

_____

_____

_____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *County* *State* *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? YES ☐ NO ☐
If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? YES ☐ NO ☐
If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? YES ☐ NO ☐
If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

## SECTION 8 – EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *County* *State* *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? YES ☐ NO ☐
If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? YES ☐ NO ☐
If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? YES ☐ NO ☐
If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

**If there are other schools, show them in Remarks, Section 10.**

E. Is the child attending Daycare/Preschool? YES ☐ NO ☐
If "YES," complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *County* *State* *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

## SECTION 9 – WORK HISTORY

A. Has the child ever worked (including sheltered work)? YES ☐ NO ☐
If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____
*(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)*

_____
*City* *State* *ZIP*

PHONE NUMBER _____ _____
*Area Code* *Number*

NAME OF SUPERVISOR _____

B. List the job title, and briefly describe the work and any problems the child may have had doing the job.

## SECTION 10 – REMARKS

**Use this section for any added information you did not show in the earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.**

## SECTION 10 – REMARKS

**ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.**

| Signature of **claimant** or person filing on claimant's behalf *(parent, guardian)* | **Date** *(Month, day, year)* |
|---|---|
| | |

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

| 1. Signature of **Witness** | 2. Signature of **Witness** |
|---|---|
| | |
| **Address** *(number and street, city, state, and ZIP code)* | **Address** *(number and street, city, state, and ZIP code)* |
| | |

## DISABILITY REPORT – CHILD - Form-SSA-3820-BK

### READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

### IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

### HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out this form before your interview appointment.
- Print or type.
- **Do Not Leave Answers Blank**. If you do not know the answers or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/ CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 10 and 11, and show the number of the question being answered.

### ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records.
- Copies of the child's prescriptions.
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

**YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE.** With your permission, we will do

that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

## The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veteran Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

**The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 40 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form.

**REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.**

Form Approved
OMB No. 0960-0623

**WHOSE *Records to be Disclosed***

*First* *Middle* *Last*

NAME

SSN | Birthday (mm/dd/yy)

**SSA USE ONLY** NUMBER HOLDER (If other than above)

NAME

SSN

# AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

**I voluntarily authorize and request disclosure** (including paper, oral, and electronic interchange):

**OF WHAT** ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

**FROM WHOM**

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

**TO WHOM** **The Social Security Administration and to the State agency authorized to process my case** (usually called 'disability determination services'), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

**PURPOSE** Determining my **eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

**EXPIRES WHEN** This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

**INDIVIDUAL authorizing disclosure**

**SIGN ▶**

**IF not signed by subject of disclosure, specify basis for authority to sign**

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian sign here if two signatures required by State law) ▶

| Date Signed | Street Address | | |
|---|---|---|---|
| Phone Number (with area code) | City | State | ZIP |

**WITNESS** *I know the person signing this form or am satisfied of this person's identity:*

**SIGN ▶**

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

**SIGN ▶**

Phone Number (or Address)

*This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.*

**Explanation of Form SSA-827,**
**"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SSA to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA 827 is provided to you in your native or preferred language.

**IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT**

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223 (d)(5)(A),1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

Other than the above limited circumstances, SSA will not redisclose without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, state, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

**PAPERWORK REDUCTION ACT**

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** ***You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.***

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

# DISABILITY DETERMINATION SERVICES (DDS) REFERRAL FORM

**TO: DISABILITY DETERMINATION SERVICES UNIT**
**5211 West Broad Street, Suite 201**
**Richmond, Virginia 23230-3032**

***RESERVED FOR DDS USE***
_____
_____
_____

***Please print or type***

## A. APPLICANT INFORMATION

SSN: _____ CASE #: _____

NAME: _____ BIRTH DATE: _____

MAILING ADDRESS: _____

_____

MEDICAID
APPLICATION DATE: _____

SSA/SSI
APPLICATION DATE: _____

IF DECEASED, DATE OF DEATH: _____ DEATH CERTIFICATE ATACHED. YES ( ) NO ( )

## B. REQUEST TO DDS FOR DISABILITY DETERMIANTION:

_____ **EXPEDITED** REFERRAL. HOSPITALIZED PATIENT REQUIRES PLACEMENT IN A REHABILITATION FACILITY AND HOSPITAL SENT DISABILITY REPORT AND RELEASE FORMS TO DDS ON _____. FAX THIS REFERRAL TO (804)-662-9366.

_____ DETERMINE DISABILITY. DISIBILITY REPORT AND RELEASE FORM(S) MUST BE ATTACHED.

_____ DETERMINE DISABILITY. SSA/SSI DENIED DISABILITY IN PAST 12 MONTHS. DISABILITY REPORT AND RELEASE FORM(S) MUST BE ATTACHED. Evaluation by DSS shows the following exception applies:

_____ Applicant alleges a new condition that has not been considered by DDS/SSA;

_____ Applicant alleges his condition has changed or deteriorated AND

- he no longer meets SSI financial requirements, but might meet Medicaid financial requirements; OR
- he has applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

_____ DETERMINE ONSET DATE OF DISABILITY. RETROACTIVE COVERAGE FOR: _____ REQUESTED. REPORT AND RELEASE FORM(S) MUST BE ATTACHED. PERIOD

Worker's
Name Printed: _____

Worker
Number: _____

FIPS Code: _____

Agency Name: _____ Phone # (___)_____

Agency Address: _____ FAX #: (___)_____

_____ Date Mailed: _____

**NOTE: <u>This referral is not valid unless it is submitted by the Department of Social Services.</u> If the applicant, another individual, or another agency completes this form, it should be sent to the local Department of Social Services. DDS cannot process forms that are incomplete or that do not have appropriate DSS identification and coding.**

**032-03-095/6 (10/04)**

## SAMPLE
## Cover Sheet for Expedited Referral to DDS and DSS

This cover sheet is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility.

**Patient:** _____ **SSN:** _____

**This individual appears to satisfy the severity and duration requirements contained in Section 223(d) and Section 1614(a) of the Social Security Act.**

**DISABILITY is defined as:**

**The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.**

**The Medicaid Application has been sent to this Dept. of Social Services:**

**Agency Name:** _____

**Agency Address:** _____

_____

**Date Mailed:** _____

**The information checked below is being faxed/overnighted to:**

**Dept. of Disability Determination Services, Medicaid Unit**
**5211 West Broad Street, Suite 201**
**Richmond, VA 23230-3032**
**Telephone – 1-800-578-3672, Fax – 1-804-662-9366**

_____ **Form SSA-3368 Disability Report Form**
_____ **SSA-827 Authorization to Disclose Information**
_____ **Medical Reports**
- _____ **Medical History & Physical, including consultations**
- _____ **Clinical fndings (such as physical/mental status examination findings)**
- _____ **Laboratory findings (such as latest x-rays, scans, pathology reports.)**
- _____ **Diagnosis.**
- _____ **A physician's statement providing an opinion about the individual's expected response to treatment and prognosis of residual capacity one year from onset.**

Specific Clinical and Laboratory Findings Generally Required to Support Diagnosis and Assess Impairment Severity:

- medically acceptable imaging - X-rays/scans/MRIs
- spirometry, DLCO (diffusing capacity of lungs for carbon monoxide), AGBS (arterial blood gas studies)
- EKGs, cardiac catheterization, echocardiogram, Doppler studies
- pathology reports
- psychological test reports

**Name of Hospital:** _____ **Date Completed:** _____

**Hospital Contact Person:** _____ **Telephone: (_____)** _____
**Please Print**

**Fax: (_____)** _____

# CHAPTER M03
# MEDICAID COVERED GROUPS
# SUBCHAPTER 20

# CATEGORICALLY NEEDY GROUPS

# TABLE OF CONTENTS

## M03 MEDICAID COVERED GROUPS

## M0320.000 CATEGORICALLY NEEDY GROUPS

# M0320.000 CATEGORICALLY NEEDY GROUPS

# M0320.001 GENERAL POLICY PRINCIPLES

**A. Overview**

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals. Most of the CN groups are mandatory; some are optional which Virginia has chosen to cover in its Medicaid state plan.

Two of the Virginia Medicaid "subclassifications," the "categorically needy non-money payment (CNNMP)" and the "medically indigent (MI)," are actually categorically needy covered groups according to the federal Medicaid law and regulations. This subchapter divides the covered groups which are classified as CN into "protected," "ABD" and "F&C" groups.

**B. Procedure**

Determine an individual's eligibility first in a categorically needy covered group. If the individual is not eligible as categorically needy, go to the medically needy groups in subchapter M0330.

The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid categorically needy covered group:

- M0320.100 Protected Covered Groups
- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII-1619(b))
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children

- M0320.200 ABD Categorically Needy Groups
- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD With Income ≤ 80% FPL

- M0320.300 Families & Children Categorically Needy Groups
- M0320.301 MI Pregnant Women & Newborn Child
- M0320.302 Family Planning Services
- M0320.303 MI Child Under Age 19
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients
- M0320.306 Low Income Families With Dependent Children (LIFC)

- M0320.307 Individuals Under Age 21
- M0320.308 Special Medical Needs Adoption Assistance Children
- M0320.309 F&C In Medical Institution, Income ≤ 300% SSI
- M0320.310 F&C Receiving Waiver Services
- M0320.311 F&C Hospice

- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

## M0320.100 PROTECTED COVERED GROUPS

**A. Legal base**

Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

**B. Procedure**

- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII)-1619(b)
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children.

## M0320.101 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972

**A. Policy**

42 CFR 435.114 and 42 CFR 435.134--The agency must provide Medicaid to individuals who meet the following conditions:

**1. Entitled to OASDI In August 1972 & Received Cash Assistance**

In August 1972, the individual was entitled to OASDI and

- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or

- he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or

- he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

**2. Would Currently Be Eligible If Increase Were Excluded**

The individual *would meet the F&C income limits for LIFC* or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the *F&C income limits or* SSI. This includes an individual who

- meets all *LIFC* requirements or current SSI requirements except for the requirement to file an application; or

- would meet all *current LIFC* or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group.

**B. Nonfinancial Requirements**

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the *F&C income limit or the current* SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; the *F&C income limits* are in subchapter M0710, Appendix 3.

**C. Procedures**

**1. Nonfinancial**

The individual must meet all nonfinancial eligibility requirements in chapter M02.

Verify the individual's receipt of OAA, AB, APTD, or AFDC cash assistance in August 1972 via agency records. Verify the cancellation of cash assistance due to the October 1972 increase in OASDI via agency records.

**2. Resources**

Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI) for aged, blind or disabled individuals, or policy in chapter M06 for Families & Children. Calculate resources according to the assistance unit policy in chapter M05.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible in another Medicaid covered group.

**3. Income**

Determine income using policy in S08 for ABD individuals, or chapter M07 for F&C individuals. Calculate income according to the assistance unit policy in chapter M05, including deeming of spouse's or parent(s)' income. Disregard the amount of the October 1972 OASDI increase and subtract the other appropriate income exclusions.

Compare the total countable income to the appropriate current SSI income limit for an ABD individual or to the *F&C* income limit for an F&C individual. If countable income is within the limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the limit, determine the individual's eligibility in another covered group.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual;
- 81 for an LIFC-related individual;
- 83 for an LIFC-UP-related individual.

## M0320.102 CONVERSION CASES

**A. Policy**

42 CFR 435.131, 435.133--Conversion cases are classified as categorically needy and consist of the following individuals:

- blind or disabled individuals eligible in December 1973;
- individuals eligible as essential spouses of aged, blind or disabled individuals in December 1973.

**B. Eligibility Determination**

The agency must continue the individual's Medicaid if

- the ABD individual continues to meet the December 1973 eligibility requirements of the applicable cash assistance program; and
- the essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the ABD individual.

**C. Essential Spouse**

The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance, if the conditions below are met. An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of cash payment to the individual under OAA, AB, or APTD in December 1973, and who is determined essential to the individual's well-being.

The spouse of the protected conversion person is included in the conversion case if:

- his/her needs were included in the OAA, AB, or APTD grant as of December, 1973, and
- he/she continues to live in the home of the protected individual.

**D. Blind or Disabled In December 1973**

The agency must provide Medicaid to individuals who:

- meet all current Medicaid eligibility requirements except the criteria for blindness or disability;
- were eligible for Medicaid in December 1973 as blind or disabled individuals; and
- for each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other eligibility requirements used under the Medicaid plan in December 1973.

**1. December 1973 Nonfinancial Eligibility Requirements**

a. The individual must meet the nonfinancial eligibility requirements:

- Citizenship/alien status (M0220);
- Virginia residency (M0230);
- Social security number provision/application requirements (M0240);
- Cooperation in pursuing support *from an absent parent (M0250);*
- Application for other benefits (M0270);
- Institutional status requirements (M0280).

b. It is not necessary to re-establish the blindness or disability requirement unless:

- the decision of the APTD Review Team or the Commission for the Visually Handicapped ophthalmologist was for a limited period, or
- the local department of social services has reason to believe the physical impairment or the visual handicap has been overcome or substantially improved.

If one of the above conditions exists, contact the Medicaid Disability Unit of the Department of Rehabilitative Services or the Department for the Visually Handicapped, as appropriate by the usual method to redetermine the individual's eligibility using the criteria followed by the former APTD Review Team or Commission for the Visually Handicapped in December, 1973.

**2. Resources**

**a. Resource Limits**

Total resources (real and personal property) may not exceed $600 for a single person, $900 for two persons and $100 for each additional person in the family unit.

**b. Home Property**

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility. A home is considered to be the house and lot or adjacent land, including a garden and outbuildings used in connection with the dwelling. It does not include land and outbuildings used for farming purposes.

**c. Income-Producing Real Property**

Ownership of income-producing real property, other than the home, such as may be used for farming or business, precludes eligibility if the equity therein of a family unit is $10,000 or more. Real property cannot be considered income-producing unless there is a reasonable annual income of approximately 10% of the market value of the property or gross income comparable to that received from similar property located in the community.

**d. Other Real Property**

Ownership of any other real property precludes eligibility unless the property cannot be sold, or sale would involve undue monetary sacrifice, or unless the market value of the property, if added to the personal property, does not exceed the allowable amount of personal property.

**e. Personal Property**

Personal property includes bank accounts, bonds, and other cash liquidable assets, and nonliquidable assets such as motor vehicles, stocks, cash value of life insurance.

When evaluating personal property, exclude

- life insurance policies with total face value of $5,000 or less for an individual,
- household equipment and furnishings,
- one motor vehicle,
- livestock providing food for family consumption
- farming or business equipment or livestock which are income-producing.

Life Insurance - When insurance (life, retirement, and other related types) has a total face value of over $5,000 for an individual, ascertain the cash value and count it as a resource. If, however, income benefits such as

disability payments are currently available under the provisions of a policy, the cash surrender value of such policy does not necessarily have to be counted as a resource, if it is in the best interest of the client and the agency for the provisions of the policy to remain unchanged.

**3. Income**

**a. Income Limits**

The annual income limits were $1,900 for one person and $2,500 for two persons.

**b. Unearned Income**

Social Security and Railroad Retirement benefits - For OAA and APTD-related persons who receive Social Security or Railroad Retirement benefits the first $4.00 monthly of such benefits for each recipient is excluded EXCEPT for the individual who is in a nursing facility and now receives $30.00 a month clothing and personal care allowance from SSI. Do not exclude $4.00 of the SSA or RR benefit received by an individual in a medical facility who now receives a $30 SSI check.

This exclusion is **not** applicable to the ineligible spouse who does not meet a Medicaid covered group.

**c. Earned Income Exclusion for OAA and APTD-related Persons**

The earned income exclusion for OAA and APTD-related individuals is the first $20 a month plus 1/2 the remainder up to a maximum of $35 per month.

**4. Resource or Income Ineligible**

If the individual no longer meets the December 1973 nonfinancial or financial eligibility requirements, the individual is not eligible in this covered group. Determine his/her eligibility in another covered group.

**E. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

# M0320.103 FORMER SSI/AG RECIPIENTS

## A. Policy

### 1. Nonfinancial Requirements

The protected former SSI/AG recipient must meet the nonfinancial eligibility requirements in chapter M02. The protected former SSI recipient is one who was eligible for and received **either:**

- SSA and SSI, or
- SSA and AG, or
- SSA, SSI, and AG

concurrently, but who became ineligible for SSI or AG due to any reason on or after April, 1, 1977. The individual did not have to be receiving Medicaid at that time.

An individual who concurrently received these benefits does not meet this covered group's requirements if one of the benefit payments was later recouped because the individual was not entitled to the payment.

### 2. Financial Requirements

The former SSI/AG recipient is eligible for Medicaid as categorically needy non-money payment if:

a. the individual meets the Medicaid resource requirements currently in effect, and the individual's income, less all SSA cost-of-living adjustments (COLAs) received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current SSI income limit; OR

b. the individual meets the AG requirements in effect at the time of application or redetermination, including residing in an approved AG home, and the individual's income less the amount of all SSA COLAs received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current AG income limit applicable to a resident of that home.

c. Any change in SSA benefits other than cost-of-living increases are not excluded, such as an increase due to change from disability benefits to widow's benefits.

**EXAMPLE #1:** Ms. C is age 71. She has never been enrolled in Medicaid before. She applied for Medicaid on February 12, 1997. She received SSA on her own record, in the amount of $280, until March 1, 1994 when she began receiving widow's benefits of $410. She received SSI until March 1, 1994, when SSI was cancelled due to her increased SSA benefit. She received COLA increases in her SSA in January of 1995, 1996, and 1997.

Her current SSA is $537. Her countable resources are less than the current Medicaid resource limit.

Ms. C meets the former SSI recipient protected individual criteria because she was eligible for and received SSA and SSI concurrently. Her countable income is her SSA amount prior to the January 1, 1997 COLA - $410 - less the $20 disregard. The result, $390, is compared to the current SSI individual limit. Because her resources are within the Medicaid limit, and her countable income of $390 is within the current SSI limit, she is eligible for Medicaid as a CNNMP protected former SSI recipient.

## B. Eligibility Procedures

### 1. Assistance Unit

If the protected individual lives with his/her spouse (or parent in the case of a blind/disabled child) whose resources and income would be counted or deemed in determining the individual's SSI or AG eligibility, the SSA cost-of-living increase(s) (COLAs) received by the spouse (or parent) since the individual lost SSI or AG eligibility is also excluded in determining the protected individual's income eligibility under this section.

Use the assistance unit composition and resource deeming procedures policy in chapter M05 to determine when a spouse's resources or income are counted or deemed in determining the individual's eligibility.

The resources and income of a parent living in the home are always deemed available in determining the blind/ disabled child's eligibility. Therefore, a parent's SSA COLAs are always excluded when determining a protected blind or disabled child's income eligibility.

### 2. Resource Eligibility

Resource eligibility is determined by comparing the former SSI recipient's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible as ABD medically indigent (which has more liberal resource methods and standards).

### 3. Income Eligibility

#### a. Allocation For NBD Child(ren)

When determining the amount of a spouse's or parent's deemable income, the allocation for a non blind or disabled (NBD) child(ren) in the home is *the same* regardless of locality (*see M0530, Appendix 1)*. On the income worksheet, insert the SSI individual payment limit whenever the worksheet calls for the Medicaid income limit.

**b. Countable Income**

In figuring income to compare to the current SSI or AG income limit, the income exclusions in chapter S08 are applicable including the $20 exclusion.

When the individual meets the above criteria for a protected case and the individual's assistance unit's resources are within the Medicaid resource limit:

1) Identify the individual's, and the individual's spouse's (or parent's when applicable), amount of Social Security Title II benefits at time of SSI termination.

   If this amount is unknown and cannot be obtained, see item 4. below.

2) When the amount of Social Security Title II benefits at time of SSI termination is determined:

   - add the Medicare premium amount to the Title II check amount if only the check amount is known (see item 5. below for Medicare premium amounts);

   - determine if any change in benefit had occurred between loss of SSI and the point of application. If questionable, multiply the prior Title II amount by the COLA percentages and compare to current entitlement. If the figures are significantly different, use the procedures in 4. below to obtain the amount of Title II at the time SSI was terminated;

   - if there were no changes, count the Title II amount at time of SSI loss. Subtract the $20 general exclusion;

   - count all other current sources of income, apply appropriate exclusions, total countable income.

**c. Income Limit**

Countable income is compared to the AG or SSI income limit for an individual or couple, as appropriate.

The SSI limit for a couple is used whenever evaluating a couple when both meet an ABD definition and both request Medicaid. The SSI limit for an individual is used when only one member of a couple applies or meets an ABD definition.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

   If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

   The non-protected spouse's eligibility is evaluated in another covered group.

2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.

3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

**4. COLA Formula**

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

*a.* *Current Title II Benefit* = *Benefit Before*
*1.027 (1/05 Increase)* *1/05 COLA*

*b.* Benefit Before 1/05 COLA = Benefit Before
1.021 (1/04 Increase) 1/04 COLA

*c.* Benefit Before 1/04 COLA = Benefit Before
1.014 (1/03 Increase) 1/03 COLA

*d.* Benefit Before 1/03 COLA = Benefit Before
1.026 (1/02 Increase) 1/02 COLA

*e.* Benefit Before 1/02 COLA = Benefit Before
1.035 (1/01 Increase) 1/01 COLA

Contact a Medical Assistance Program Specialist for amounts for years prior to *2001*.

**5. Medicare Premiums**

**a. Medicare Part B premium amounts:**

*1-1-05 $78.20*
1-1-04 $66.60
1-1-03 $58.70
1-1-02 $54.00
1-1-01 $50.00

**b. Medicare Part A premium amounts:**

*1-1-05 $375.00*
1-1-04 $343.00
1-1-03 $316.00
1-1-02 $319.00
1-1-01 $300.00

Contact a Medical Assistance Program Specialist for amounts for years prior to *2001*.

**6. Classification**

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future CNNMP protection as the SSI and AG income limits increase.

**C. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible former SSI or AG recipients in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

**D. Eligibility for Non-Protected Family Members**

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

## M0320.104 PROTECTED WIDOWS OR WIDOWERS

**A. Policy**

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)'s benefits have their Medicaid categorically needy eligibility protected. The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984. The second group consists of disabled widow(er)s age 60 through 64 who would be eligible for SSI except for early receipt of Social Security benefits.

**B. July 1989 Protected Widow(er)s**

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,
- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- were entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

**1. Nonfinancial Eligibility**

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

a. meets the nonfinancial eligibility requirements in chapter M02;

b. applied for Medicaid as a protected individual prior to July 1, 1989;

c. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;

d. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:

- the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,

- he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and

- a retroactive payment of that increase for prior months was not made in that month;

e. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month that the increase in his/her widow(er)'s benefit was received;

f. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.

**2. Financial Eligibility**

**a. Assistance Unit**

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

**b. Asset Transfer**

The protected individual must meet the asset transfer policy in *subchapter M1450*.

**c. Resource Eligibility**

Resource eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

**d. Income Eligibility**

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected

individual is eligible for Medicaid in this protected CNNMP covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

**C. Protected Disabled Widow(er) Age 60 Through 64**

42 CFR 435.138 - A protected disabled widow(er) age 60 through 64 is an individual who:

- is at least age 60 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)'s benefit were excluded from income.

**1. Nonfinancial Eligibility**

The protected disabled widow(er) must:

a. meet the nonfinancial eligibility requirements in chapter M02;

b. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;

c. be eligible for SSI or AG if the SSA widow(er)s disability benefit were not counted as income.

**2. Financial Eligibility**

**a. Assistance Unit**

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

**b. Asset Transfer**

The protected individual must meet the asset transfer policy in Part II Chapter C.

**c. Resource Eligibility**

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

**c. Income Eligibility**

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's *countable* income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income

is within that limit, the protected individual is eligible for Medicaid in this protected group.

3) If the individual is not income eligible, *the individual must be evaluated for Medicaid eligibility in other covered groups.* However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

## M0320.105 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)-1619(B) STATUS

**A. Introduction**

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, *a* disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continue*s* to have a disabling impairment can continue to receive special SSI benefits if *he* continue*s* to be financially eligible for SSI benefits based on income. Section 1619(b) of the Act allows *a* disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and *a* blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an *individual who who lost SSI because of earned income* is eligible for 1619(b) status.

*The local department of social services determines whether an individual who has a 1619(b) status continues to be eligible for Medicaid.*

***B.* Identifying QSII Individuals**

*To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status.*

Since eligibility for 1619(b) can change, *check* the *SVES* at each redetermination and when there is an indication that a change may have occurred.

## C. Determining Eligibility

### 1. Nonfinancial Eligibility

The QSII individual must:

- meet the nonfinancial eligibility requirement in chapter M02, and
- have been eligible for and receiving Medicaid coverage *as an SSI recipient (must have met the more restrictive real property requirement)* in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

### 2. Financial Eligibility

***a. Resource Eligibility***

*Determine if the QSII recipient has the following real property resource(s):*

1) *equity in non-exempt property contiguous to his/her home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;*

2) *an interest in undivided heir property and the equity value of his/her share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;*

3) *ownership (equity value) of his/her former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;*

4) *equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;*

5) *other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.*

*When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements.*

*Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).*

***b. Income Eligibility***

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

**D. Entitlement & Enrollment**

Eligible individuals are entitled to full Medicaid coverage. They are classified as categorically needy non-money payment (CNNMP) recipients. The program designation is:

- 21 for an aged individual;
- 41 for a blind individual; *or*
- 61 for a disabled individual.

**E. Individuals Ineligible as QSII**

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or

- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

## M0320.106 PROTECTED ADULT DISABLED CHILDREN

**A. Policy**

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and

- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

**B. Nonfinancial Eligibility**

A protected adult disabled child is one who:

- meets the nonfinancial eligibility requirements in chapter M02;

- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;

- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;

- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;

- has resources within the current Medicaid resource limit; and

- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

**C. Financial Eligibility**

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

**1. Resources**

**a. Asset Transfer**

The protected individual must meet the asset transfer policy in *subchapter M1450.*

**b. Resource Eligibility**

Financial eligibility is determined by comparing the protected individual's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

**2. Income**

**a. Receipt of SSA Child's Benefits Causes SSI Ineligibility**

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this CNNMP protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

**b. Increase In SSA Child's Benefits Causes SSI Ineligibility**

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI

ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this CNNMP protected covered group.

   In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.103 of this chapter.

2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

## M0320.107 *PROTECTED SSI DISABLED CHILDREN*

***A. Introduction***

*The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.*

***B. Nonfinancial Eligibility Requirements***

*To be eligible in this protected covered group, the protected SSI disabled child must*

- *have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);*
- *meet the nonfinancial Medicaid eligibility requirements in chapter M02;*
- *continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and*
- *be under age 18 years.*

***1. Disability Determination***

*An SSI disabled child is presumed to meet the childhood disability definition in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete*

- *the "Disability Referral Form" (form #032-03-095);* ***and***
- *the "Medical History and Disability Report" (form #032-03-007) and the "Psychological/Psychiatric Supplement" if appropriate;* ***and***
- *a "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.*

*Send the report(s) and authorization forms to the MDU.*

***2. MDU Decision***

*If the MDU decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the CNNMP protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.*

*If the MDU decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the CNNMP protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.*

***C. Financial Eligibility Procedures***

***1. Assistance Unit***

*Follow the policy and procedures in M0530.*

. ***2. Resource Eligibility***

*Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in subchapter M0530. If current resources are within the limit, go on to determine income eligibility.*

*If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as F&C medically indigent if he/she is under age 19 years.*

***3. Income Eligibility***

*Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.*

***D. Entitlement & Enrollment***

*Children eligible for Medicaid in the covered group of protected SSI disabled children are classified as categorically needy non-money payment (CNNMP). Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.*

*Eligible protected SSI disabled children are enrolled with program designation "61."*

## M0320.200 ABD CATEGORICALLY NEEDY

**A. Introduction**

To be eligible in an ABD (aged, blind or disabled) covered group, the individual must first meet the "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he/she does not, then go to the Families & Children Categorically Needy covered groups in section M0320.300 below.

**B. Procedure**

The policy and procedures for determining whether an individual meets an ABD CN covered group are contained in the following sections:

- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income _ 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- *M0320.210 ABD with Income ≤ 80% FPL.*

## M0320.201 SSI RECIPIENTS

**A. Introduction**

42 CFR 435.121 - SSI recipient are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local department of social services.

**B. Nonfinancial Eligibility**

An individual who is receiving an SSI payment is eligible for Medicaid if he/she meets the following nonfinancial requirements:

**1. Citizenship or Alien Status**

The SSI recipient is a citizen of the United States or full benefit alien (see M0220).

**2. Virginia Residency**

The SSI recipient is a resident of Virginia (see M0230).

**3. Assignment Of Rights**

The SSI recipient meets the assignment of rights to medical support and third party payments requirements (see M0250).

**4. Institutional Status**

The SSI recipient meets the institutional status requirements in M0280.

**5. Not Conditionally Or Presumptively Eligible**

The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

**6. SSI Entitlement**

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.

**C. Financial Eligibility**

**a. Asset Transfer**

**1. Resources**

The SSI recipient must meet the asset transfer policy in *subchapter M1450.* See *subchapter* M1450 to determine if the asset transfer

precludes Medicaid eligibility or eligibility for Medicaid payment of long-term services.

**b. Resource Eligibility**

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his/her home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) an interest in undivided heir property and the equity value of his/her share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of his/her former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements.

Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

**2. Income**

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he/she meets the Medicaid income eligibility requirement.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month.

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactive period, the individual is not eligible for retroactive Medicaid in the SSI recipients covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

Eligible SSI recipients are classified as categorically needy (CN). Program designation is

- 11 for an aged SSI recipient;
- 31 for a blind SSI recipient;
- 51 for a disabled SSI recipient.

**E. Ineligible as SSI Recipient**

If a non-institutionalized SSI recipient is not eligible for Medicaid because of resources, *evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income ≤ 80% FPL and QMB covered groups.*

## M0320.202 AG RECIPIENTS

**A. Policy**

42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he/she meets the assignment of rights to medical support and third party payments requirements (see M0250) and the asset transfer policy in *subchapter M1450*. AG eligibility is determined using the AG eligibility policy in Volume II.

**B. Procedure**

Verify the AG recipient's eligibility for AG by agency records.

**C. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

AG recipients are classified as categorically needy (CN). Program designation is

- 12 for an aged AG recipient;
- 32 for a blind AG recipient;
- 52 for a disabled AG recipient.

# M0320.203 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

**A. Policy**

42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions who

- meet the Medicaid resource requirements, and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

**B. Nonfinancial Eligibility**

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is institutionalized in a medical institution that is not an IMD;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the Aged, Blind, or Disabled definition in M0310.

**C. Financial Eligibility**

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Resources**

**a. Resource Eligibility - Married Individual**

If the individual is married, use the resource policy in subchapter M1480. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

**b. Resource Eligibility - Unmarried Individual**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to:

1) equity In non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property; and

2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

**3. Income**

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and subchapter M1460*.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% of SSI limit (see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB limit.

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is:

- 22 for an aged individual also QMB;
- 42 for a blind individual also QMB;
- 62 for a disabled individual also QMB.

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 20 for an aged individual NOT also QMB;
- 40 for a blind individual NOT also QMB;
- 60 for a disabled individual NOT also QMB.

**E. Ineligible In This Covered Group**

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. *If the individual is not eligible for Medicaid in this covered group because of resources*, determine the individual's eligibility as QMB, SLMB, QDWI *or QI* if he/she has Medicare Part A.

## M0320.204 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

**A. Policy**

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit *(see M0810.002 A. 3.)*.

**B. Nonfinancial Eligibility**

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the Aged, Blind, or Disabled definition in M0310.

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is screened and approved *(*see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

## C. Financial Eligibility

### 1. Asset Transfer

The individual must meet the asset transfer policy in *subchapter* M1450.

### 2. Resources

#### a. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and

2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

**b. Resource Eligibility - Married Individual**

If the individual is married *and has a community spouse*, use the resource policy in *subchapter M1480*. *If the individual is married, but has no community spouse, use the resource policy in subchapter M1460.* Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

**3. Income**

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and subchapter M1460.*

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% of SSI limit (see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met AND they receive waiver services in that month. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

Eligible and entitled individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB limit.

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is:

- 22 for an aged individual also QMB;
- 42 for a blind individual also QMB;
- 62 for a disabled individual also QMB.

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 20 for an aged individual NOT also QMB;
- 40 for a blind individual NOT also QMB;
- 60 for a disabled individual NOT also QMB.

**E. Ineligible In This Covered Group**

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

## M0320.205 ABD HOSPICE

**A. Policy**

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and who elect hospice benefits.

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

*Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470).*

**B. Nonfinancial Eligibility**

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;

7. Is not living in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the Aged, Blind, or Disabled definition in M0310. **If the individual has not been determined disabled, he/she is "deemed" to be disabled because of the terminal illness. Do not refer the individual to the *DDS*.**

The individual must elect hospice care. Election of hospice care is verified either *verbally* or in writing from the hospice. If the verification is *verbal*, document case record.

## C. Financial Eligibility

### 1. Asset Transfer

*The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.*

### 2. Resources

#### a. Resource Eligibility

The hospice services recipient is an assistance unit of 1 person. **If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married but has no community spouse, use the resource policy in subchapter M1460.**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and

2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

Deem any resources from the individual's spouse living in the home in accordance with policy in subchapter M1480. If the individual is a child, do **not** deem any resources from the child's parent.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent.

**3. Income**

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and subchapter M1460*.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% of SSI limit (see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

**D. Entitlement & Enrollment**

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - apply appropriate exclusions. Compare the countable income to the QMB limit.

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is:

- 22 for an aged individual also QMB;
- 42 for a blind individual also QMB;
- 62 for a disabled individual also QMB.

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 20 for an aged individual NOT also QMB;
- 40 for a blind individual NOT also QMB;
- 60 for a disabled individual NOT also QMB;

- 54 for an individual who meets an F&C category or does not meet a category and is "deemed" disabled.

**E. Ineligible In This Covered Group**

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

## M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)

**A. Policy**

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources (as determined for SSI purposes) that do not exceed twice the SSI resource limit; and
- has income that does not exceed 100% of the federal poverty limits.

**B. Nonfinancial Eligibility**

The Qualified Medicare Beneficiary must meet all the nonfinancial eligibility requirements in chapter M02.

**1. Entitled to Medicare Part A**

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

**2. Individual Not Currently Enrolled In Medicare Part A**

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of *Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as QMB.*

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.

**3. Verification Not Provided**

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

**C. Financial Eligibility**

**1. Assistance Unit**

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QMB determination; the other is for the ABD spouse's CN or MN covered group.

**2. Resources**

The asset transfer rules in *subchapter* M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 2 to Chapter S11 must be met by the medically indigent Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11).

**3. Income**

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. By law, for QMBs who have Title II benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For QMBs who do NOT have Title II benefits, the new QMB income limits are effective the date the updated federal poverty limit is published. *Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QMB income eligibility.*

**4. Income Exceeds QMB Limit**

Spenddown does not apply to the medically indigent income limits. If the individual's income exceeds the QMB limit, he/she is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the Special Low-income Medicare beneficiary (SLMB) covered group below in M0320.207.

*At application and redetermination*, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on *two 6-month* spenddown*s* based on the MN income limit.

**D. QMB Entitlement**

Entitlement to Medicaid coverage for a QMB who does not also meet the requirements of another categorically needy, CNNMP, or medically needy covered group (is QMB only, **not** dually-eligible) begins the **first day of the month <u>following</u> the month in which his/her Medicaid eligibility as a QMB is <u>determined</u>.**

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group in the retroactive period and application month.

**E. Enrollment**

**1. Program Designations**

The following program designations (PDs) are used to enroll individuals who are only eligible as qualified Medicare beneficiaries; they do not meet the requirements of another covered group:

- 23 for an aged QMB only;
- 43 for a blind QMB only;
- 63 for a disabled or end-stage renal disease QMB only.

**2. Recipient's PD Changes To QMB**

An enrolled recipient's PD cannot be changed to the QMB only PDs using a "change" transaction in the MMIS. If a Medicaid recipient becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the

agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Program designation is QMB-only.

**3. QMB's PD Changes To Full Coverage PD**

When an enrolled QMB-only becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "24";

- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage classification and covered group, with the appropriate full coverage PD.

**4. Spenddown Status**

*At application and redetermination*, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on *two 6-month* medically needy spenddown*s*.

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

**5. QMB Meets Spenddown**

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is medically needy dual-eligible:

- 28 for an aged MN individual also eligible as QMB;
- 48 for a blind MN individual also eligible as QMB;
- 68 for a disabled MN individual also eligible as QMB.

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

**6. Spenddown Period Ends**

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation.

The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

**7. QMB Enters Long-term Care**

The enrollment of a QMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QMB who meets a spenddown. Cancel the QMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "24". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

## M0320.207 SLMB (SPECIAL LOW INCOME MEDICARE BENEFICIARY)

**A. Policy**

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act - Coverage of Special Low-income Medicare Beneficiaries is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part B premium for individuals eligible as SLMB.

An SLMB is an individual who meets all of the eligibility requirements for QMB (M0320.206 above) EXCEPT for income that exceeds the QMB limit but is less than the higher limit for SLMB. Like QMBs, eligible SLMBs who meet an MN covered group are also placed on a medically needy spenddown if resources are within the medically needy limit.

An SLMB individual

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources (as determined for SSI purposes) that do not exceed twice the SSI resource limit; and
- has income that exceeds the QMB limit (100% of the federal poverty limits) but is less than 120% of the poverty limits.

**B. Nonfinancial Eligibility**

The SLMB must meet all the nonfinancial eligibility requirements in chapter M02.

**1. Entitled to Medicare Part A**

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

**2. Individual Not Currently Enrolled In Medicare Part A**

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as an SLMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.

**3. Verification Not Provided**

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

## C. Financial Eligibility

**1. Assistance Unit**

The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent SLMB determination; the other is for the ABD spouse's CN or MN covered group.

**2. Resources**

The asset transfer rules in *subchapter M1450* must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix *2* to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix *2* to chapter S11).

**3. Income**

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty limit is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

**4. Income Equals or Exceeds SLMB Limit**

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddown*s* based on the MN income limit.

**D. SLMB Entitlement**

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

The eligible SLMB will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The SLMB will not receive a Medicaid card.**

**E. Enrollment**

**1. Program Designation**

The PD (program designation) for all SLMBs is "53".

**2. Recipient's PD Changes To SLMB**

An enrolled recipient's PD cannot be changed to PD "53" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because

of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Program designation is "53".

**3. SLMB's PD Changes To Full Coverage PD**

When an enrolled SLMB becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "24";
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage PD.

**4. Spenddown Status**

*At application and redetermination*, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on *two 6-month* medically needy spenddown*s*.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

**5. SLMB Meets Spenddown**

When an SLMB meets a spenddown, cancel his PD "53" coverage effective the date before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is medically needy NOT dual-eligible:

- 18 for an aged MN individual NOT eligible as QMB;
- 38 for a blind MN individual NOT eligible as QMB;
- 58 for a disabled MN individual NOT eligible as QMB.

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

**6. Spenddown Period Ends**

After the spenddown period ends, reinstate the SLMB-only coverage using the PD 53.

The begin date of the reinstated PD 53 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

**7. SLMB Enters Long-term Care**

The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "24". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

## M0320.208 QUALIFIED INDIVIDUALS-*(QI)*

**A. Policy**

*P.L. 105-33 (Balanced Budget Act of 1997) – mandated Medicaid* coverage of Qualified Individuals *who* would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. When *implemented on January 1, 1998, the QI covered group consisted of two components, Group 1 and Group 2. Group 1 individuals receive Medicaid coverage for the payment of their Medicaid Part B premium. Group 2 individuals receive Medicaid coverage for the portion of the Medicare Part B premium that is attributable to the cost of transferring coverage of home health services to Medicare Part B from Part A. The federal authority for Group 2 expired and Medicaid coverage for this component ended December 31, 2002. Effective January 1, 2003, the QI covered group consists only of the component formerly referred to as "Group 1".*

Like QMBs and SLMBs, eligible QIs are also placed on a medically needy spenddown if resources are within the medically needy limit.

**1. Not An Entitlement**

Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.

Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.

**2. Qualified Individual (QI)**

A Qualified Individual (QI)

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);
- has resources that do not exceed twice the SSI resource limit; and
- has income that is equal to or exceeds the SLMB limit (120% of the federal poverty limit) but is less than the QI limit (135%of the poverty limit).

**B. Nonfinancial Eligibility**

QIs must meet all the nonfinancial eligibility requirements in chapter M02.

**1. Entitled to Medicare Part A**

The QI must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

**2. Individual Not Currently Enrolled In Medicare Part A**

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as QI.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must

present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QI.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.

**3. Verification Not Provided**

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QI, but may be eligible in another covered group.

**C. Financial Eligibility**

**1. Assistance Unit**

The ABD assistance unit policy in chapter M05 applies to Qualified Individuals.

If the QI is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QI determination; the other is for the ABD spouse's CN, CNNMP or MN covered group.

**2. Resources**

*The asset transfer rules in subchapter M1450 must be met by the QI.*

The resource requirements for QMBs in chapter S11 and Appendix 2 to Chapter S11 must be met by the QI.

The resource limit for a QI is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11 for resource requirements and limits).

**3. Income**

The income requirements in chapter S08 must be met by the QI. The income limits for QIs are in M0810.002. A QI's countable income must exceed the SLMB limit and must be less than the QI limit.

By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.

**4. Income Within QI Limit**

When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below.

**5. Income Equals or Exceeds QI Limit**

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the QI limit (135% of FPL), **he/she is not eligible as QI** and cannot spenddown to the QI limit.

**D. QI Coverage Period**

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group. Coverage under this group cannot begin earlier than January 1 of the calendar year. The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

**E. Covered Service**

The eligible QI will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The QI will not receive a Medicaid card.**

**F. Enrollment**

**1. Program Designation**

QI = 56

**2. Eligibility Type**

The eligibility type is "Type 1" for ongoing.

**3. Begin and End Dates**

The begin date of coverage cannot be any earlier than January 1 of the calendar year.

Do not enter an end date of coverage. The MMIS will automatically cancel the recipient's coverage on December cut-off, effective December 31 of the calendar year.

**4. Recipient's Covered Group Changes To QI**

**a. Before November Cut-off**

An enrolled recipient's PD cannot be changed to PD "56" using a "change" transaction in the MMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate program designation.

**b. After November Cut-off**

If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "07".

## G. MMIS Procedures For QI Recipients

The MMIS computer will

- automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

# M0320.209 QDWI (QUALIFIED DISABLED & WORKING INDIVIDUALS)

**A. Policy**

42 CFR 435.121 - Coverage of Qualified Disabled & Working Individuals is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part A premium for individuals eligible as QDWI.

**B. Nonfinancial Eligibility**

The QDWI must meet all the nonfinancial eligibility requirements in chapter M02.

**1. Definition Requirements**

The individual must:

- be less than 65 years of age.
- be employed.
- have been entitled to Social Security disability benefits and Medicare Part A but lost entitlement solely because earnings exceeded the substantial gainful activity (SGA) amount.
- continue to have the disabling physical or mental impairment or be blind as defined by SSI and Medicaid but because he/she is working and earning income over the SGA limit does not meet the disability definition.
- be eligible to enroll or be enrolled in Medicare Part A (hospital insurance) under Section 1818A of the Social Security Act.
- not be eligible for Medicaid in any other classification or covered group.

The above definition requirements must be verified by the Social Security Administration (SSA). The individual must be enrolled in Medicare Part A under Section 1818-A of the Social Security Act. Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with SSA.

NOTE: Blind individuals who lose SSA and Medicare because of earnings over SGA still meet the blind category for Medicaid purposes. Therefore, a blind individual whose countable

income is within CNNMP, medically needy, or QMB limits cannot be eligible as a qualified disabled and working individual.

**2. Verification Not Provided**

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QDWI, but may be eligible in another covered group.

**C. Financial Eligibility**

The assistance unit policy in chapter M05 applies to QDWIs.

**1. Assistance Unit**

If the QDWI individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QDWI determination; the other is for the ABD spouse's covered group.

**2. Resources**

The asset transfer rules in *subchapter M1450* must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 1 to chapter S11).

**3. Income**

QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

**4. Income Exceeds QDWI Limit**

Spenddown does not apply to the medically indigent income limits. If the individual's income exceeds the QDWI limit, he/she is not eligible as QDWI and cannot spenddown to the QDWI limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddown*s* based on the MN income limit.

**D. Entitlement**

Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

The eligible QDWI will only receive Medicaid payment of his/her Medicare Part A premium through the Medicaid Buy-In Agreement with SSA. **The QDWI will not receive a Medicaid card.**

**E. Enrollment**

**1. Program Designation**

The PD (program designation)*)* for all QDWIs is "55."

**2. Recipient's PD Changes To QDWI**

An enrolled recipient's PD cannot be changed to PD "55" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "07." Reinstate the recipient's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. Program designation is "55."

**3. QDWI's PD Changes To Full Coverage PD**

When an enrolled QDWI becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "24;"

- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage PD.

**4. Spenddown Status**

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddown*s*.

**5. QDWI Meets Spenddown**

When a QDWI meets a spenddown, cancel his PD "55" coverage effective the date before spenddown was met using cancel reason "24." *Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.*

The PD is NOT dual-eligible:

- 18 for an aged MN individual NOT eligible as QMB;
- 38 for a blind MN individual NOT eligible as QMB;
- 58 for a disabled MN individual NOT eligible as QMB.

**6. Spenddown Period Ends**

After the spenddown period ends, reinstate the QDWI-only coverage using the PD "55."

The begin date of the reinstated PD "55" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

**7. QDWI Enters Long-term Care**

The enrollment of a QDWI who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QDWI who meets a spenddown. Cancel the QDWI-only coverage effective the last day of the month before the admission to long-term care, reason "24." Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

## M0320.210 ABD WITH INCOME ≤ 80% FEDERAL POVERTY LIMIT (FPL)

**A. Policy**

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

*Eligibility in the ABD 80% FPL covered group is limited to those ABD individuals who do not meet the requirements for any other full benefit Medicaid covered group. ABD individuals who meet the requirements for the 300% SSI covered groups (see M0320.203 and 204) or are medically needy without a spenddown (see M0330) are to be enrolled in these groups and not in the ABD 80% FPL covered group.* An eligible individual's resources must be within the SSI resource limits.

**B. Nonfinancial Eligibility**

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

**C. Financial Eligibility**

**1. Asset Transfer** — The individual must meet the asset transfer policy in subchapter M1450.

**2. Assistance Unit** — The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

**3. Resources** — The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

**4. Income** — The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

**5. Income Exceeds 80% FPL** — **Spenddown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he/she is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

***D.* Entitlement**

**1. Begin Date** — Eligibility in the ABD 80% FPL covered group cannot begin earlier than July 1, 2001. If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month, but no earlier than July 1, 2001.

**2. Retroactive Entitlement** — ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period, but no earlier than July 1, 2001.

**E. Enrollment** — The program designations are:

- 29 for an aged recipient;
- 39 for a blind recipient; or
- 49 for a disabled recipient.

# M0320.300 FAMILIES & CHILDREN CATEGORICALLY NEEDY

**A. Introduction**

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman definition in M0310, or BCCPTA definition in M0310.

The F&C CN covered groups are divided into the medically indigent (MI), CN and CNNMP classifications. First determine if the F&C individual meets an MI covered group. If the individual does not meet an MI covered group, then determine if the individual meets the requirements of an F&C CN or CNNMP covered group.

**B. Procedure**

The policy and procedures for determining whether an individual meets an F&C MI, CN or CNNMP covered group are contained in the following sections:

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Family Planning Services *(FPS)*;
- M0320.303 MI Child Under Age 19 *(FAMIS Plus);*
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients;
- M0320.306 Low Income Families With Children (LIFC);
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income $\leq$ 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA*)*.

# M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN

**A. Policy**

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty limit. The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

**B. Nonfinancial Eligibility**

**1. Pregnant Woman**

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

The MI pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

**2. Newborn Child**

42 CFR 435.117 - A child born to a *woman* who was eligible for Medicaid *(including Medicaid payment for labor and delivery as an emergency services alien)* at the time the child was born is eligible as a newborn child under age 1 year. The child remains eligible for Medicaid as long as the mother remains eligible for Medicaid or would be eligible if she were still pregnant, and they live together.

**a. Eligible To Age 1**

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1 as long as the following conditions are met:

1) the child remains in the home with the mother, and

2) the child's mother remains eligible for Medicaid or the child's mother would be eligible for Medicaid if she were *still* pregnant.

**b. Living With Mother**

A newborn child is considered living with its mother from the moment of birth until the child is

- entrusted or committed into foster care,
- institutionalized, or
- goes to live with someone other than the child's mother.

**c. No Other Nonfinancial Eligibility Requirements**

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

## C. Financial Eligibility

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the pregnant woman's financial eligibility.

If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

**3. Resources**

There is no resource limit.

**4. Income**

The income requirements in chapter M07 must be met by a pregnant woman. The income limits are 133% of the federal poverty limit and are found in subchapter M710, Appendix 6.

**5. Income Changes After Eligibility Established**

*Once eligibility is established as a pregnant woman, changes in income do not affect her and her newborn's eligibility as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements. This also includes situations where eligibility is established in the retroactive period.*

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning *$3,000* a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1. Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

**6. Income Exceeds MI Limit**

Spenddown does not apply to the medically indigent. If the applicant's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses.

Eligibility as medically needy must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

**D. Entitlement**

Eligible MI pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if pregnancy is verified as existing in the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. *A Medicaid application for the newborn child is not required until the month in which the child turns age 1.*

Eligible medically indigent pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her

pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

**E. Enrollment**

The PD (program designation) for MI pregnant women is "91."

The PD for MI newborns is "93."

## M0320.302 FAMILY PLANNING SERVICES (FPS)

**A. Policy**

Chapter 899 of the 2002 Acts of Assembly, Item 325 M, directs DMAS to provide payment for Family Planning Services (FPS). Effective October 1, 2002, women who receive a pregnancy-related service paid for by Medicaid may receive up to 24 months of family planning services following the end of their pregnancy. Since women enrolled in the MI Pregnant Woman covered group receive 60 days of postpartum coverage with full Medicaid benefits, they are eligible to receive 22 months of family planning services following the end of their pregnancy and the 60-day postpartum period. For women who received a pregnancy-related service paid for by Medicaid for the period October 1, 2002 through September 30, 2003, an eligibility determination must be completed. These women must continue to meet the income requirements of the MI Pregnant Woman covered group to be enrolled in the FPS covered group.

Effective October 1, 2003, women eligible in the MI Pregnant Woman covered group who receive a pregnancy-related service paid for by Medicaid on or after October 1, 2003, are eligible for the FPS covered group following the end of the 60-day postpartum period; an eligibility determination is not required. Changes in income do not affect eligibility for 12 months following the end of the pregnancy. A redetermination of eligibility must be completed 12 months after the date the pregnancy ended. If the woman remains eligible, she is entitled to an additional 12 months of FPS coverage.

Women who received a pregnancy-related service paid for by Medicaid and were enrolled in a covered group other than MI Pregnant Women may be eligible for the FPS covered group if their income is less than or equal to 133% FPL. These women are subject to an eligibility determination.

Eligibility in the FPS covered group can extend no longer than the 24$^{th}$ month following the end of the pregnancy.

Retroactive coverage is available for FPS.

**B. Nonfinancial Requirements**

Women in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status (emergency services aliens described in M0220.700 are not eligible);Virginia residency;
- Social Security number;
- assignment of rights to medical benefits;
- application for other benefits; and
- institutional status.

Women who *have been determined eligible* for a full benefit Medicaid covered group are not eligible for this covered group. Medicaid recipients who were not enrolled in Medicaid as a MI pregnant woman (PD 91) or as a MN pregnant woman (PD 97) must provide proof of the pregnancy in order to meet this covered group. DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for the FPS covered group.

**C. Financial Eligibility**

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the FPS financial eligibility.

**2. Asset Transfer**

The asset transfer rules do not apply to the FPS covered group.

**3. Resources**

There is no resource limit.

**4. Income**

The income requirements in chapter M07 must be met for the FPS covered group. The income limits are 133% of the FPL and are found in subchapter M710, Appendix 6.

An income eligibility determination is not required for women enrolled in the MI Pregnant Women covered group who received a Medicaid covered pregnancy-related service on or after October 1, 2003. They are deemed to be income-eligible for FPS for the first 12 months following the end of their pregnancy. These women must be determined income-eligible to receive FPS for the second 12 months following the end of the pregnancy.

An income eligibility determination is required for:

- women enrolled in the MI Pregnant Women covered group who received a Medicaid covered pregnancy-related service whose pregnancy ended on or after October 1, 2002, but prior to October 1, 2003; and

- women who were not enrolled in the MI Pregnant Women covered group before their pregnancy ended but who received a Medicaid covered pregnancy-related service on or after October 1, 2002.

**5. Spenddown**

Spenddown does not apply to this covered group.

**D. Entitlement *and Enrollment***

*Eligibility in the FPS covered group can extend no longer than the 24th month following the end of the pregnancy.*

*The eligibility worker must cancel the MI Pregnant Women enrollment effective the last day of the month of the 60-day postpartum period and enroll the woman in FPS the first day of the following month. An eligibility determination is not required for those MI Pregnant Women whose pregnancy ends on or after October 1, 2003.*

*Women who were not enrolled in the MI Pregnant Women covered group who had a Medicaid covered pregnancy-related service must have an eligibility determination. If the woman does not meet a covered group entitled to full Medicaid benefits, but meets the requirements of the FPS covered group she is to be enrolled in FPS.*

The PD for FPS is "80".

*Written notice must be sent to inform the recipient of her eligibility in the FPS covered group and of the reduction in coverage. She must also be advised of the opportunity to receive a redetermination of eligibility for full coverage.*

The eligibility worker must code the special review field in the MMIS with FPMM*DDCC*YY (family planning, month, *day, century* and year the pregnancy ended). When this special review code is used, the MMIS will automatically send the advance notice and cancel FPS coverage 24 months after the pregnancy ends.

The MMIS will cancel this coverage using reason code "36".

## M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)

**A. Policy**

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits. Virginia has elected to cover children between the ages of 6 and 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

**B. Nonfinancial Eligibility**

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, *provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.*

**C. Financial Eligibility**

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

**3. Resources**

There is no resource limit.

**4. Income**

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

**D. Income Changes**

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

**6. Income Exceeds MI Limit**

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

**D. Entitlement**

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

**E. Enrollment**

The PDs for the MI child are:

| PD | Meaning |
|---|---|
| 90 | MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL |
| 91 | MI child under age 6; income less than or equal to 100% FPL |
| 92 | • MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL;<br>• MI child age 6-19; **insured** with income greater than 100% FPL and less than or equal to 133% FPL |
| 94 | MI child age 6-19; **uninsured** with income greater than 100% FPL and less than or equal to 133% FPL |

Do not change the PD when a child's health insurance is paid for by Medicaid through the HIPP program.

# M0320.305 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

**A. Policy**

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

**B. Nonfinancial Eligibility**

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support. Check the following nonfinancial requirements:

- citizenship or alien status (M0220);
- Social Security account number (M0240);
- assignment of rights (M0250);
- application for other benefits (M0270);
- institutional status (M0280).

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

**C. Children Who Receive SSI**

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid as SSI recipients.

**D. Financial Eligibility**

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E payment eligibility via agency records.

**E. Entitlement**

**1. IV-E Foster Care Child**

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

**2. IV-E Adoption Assistance Child**

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

**F. Enrollment**

The PD (program designation) for children who receive IV-E payments is "74."

## M0320.306 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

**A. Policy**

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 19 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children

and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called "Low Income Families With Children (LIFC).

**B. Nonfinancial Eligibility**

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. A child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113.

**C. Financial Eligibility**

**1. Assistance Unit**

The assistance unit policy in subchapter M0520 applies to the LIFC covered group. The assistance unit's financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the amount for the individual's covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC resource and income limits, because of the different resource and income rules and the different resource and income limits used in the F&C and ABD determinations.

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 must be met by an LIFC individual.

**3. Resources**

*There is no resource test for the LIFC covered group.*

**4. Income**

***a. Non-View Participants***

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

***b. View Participants***

*The income requirements in chapter M07 must be met by the VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.*

**5. Income Exceeds CNNMP Limit**

Spenddown does not apply to the CNNMP income limits. If the family/budget unit's (FU/BU's) income exceeds the F&C CNNMP income limit, the unit is not eligible as CNNMP LIFC and cannot spenddown to the CNNMP limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18.

**D. Entitlement**

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

**E. Enrollment**

The PD (program designation) for individuals in the LIFC covered group are:

- 81 for LIFC individual;
- 83 for LIFC-UP individuals.

## M0320.307 INDIVIDUALS UNDER AGE 21

**A. Policy**

42 CFR 435.222 - The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the resource and income requirements of the state's July 16, 1996 AFDC State Plan. These reasonable classifications of individuals under age 21 are:

- individuals in foster homes, private institutions or independent living arrangements for whom a public agency is assuming full or partial financial responsibility;

NOTE: A foster care child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group;

- individuals placed in foster homes or private institutions by private nonprofit child placing agencies;

- individuals in adoptions subsidized in full or in part by a public agency;
- individuals in nursing facilities;
- individuals in intermediate care facilities for the mentally retarded (ICF-MRs).

When a child is under age 19, first determine the child's eligibility in the MI *Child Under Age 19* covered group (M0320.303). If the child is *ineligible* as MI, and the child meets the requirements of the "individuals under age 21" covered group, enroll the child in Medicaid using one of the PDs in item D. below.

**B. Nonfinancial Eligibility**

The child must be under age 21 and must meet the nonfinancial requirements in chapter M02.

**1. Non IV-E Foster Care**

Children who meet the foster care definition in M0310.115, but who are not IV-E eligible, are "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

**a. Child Placed in Home For Trial Visit**

A child also meets the non-IV-E foster care definition when placed by the agency in the child's own home for a "trial" period of up to three months if the child continues to be in the agency's custody.

**b. Child in Independent Living Arrangement**

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is in the local social services agency's legal custody. A foster child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group.

**2. Juvenile Justice Department Children**

Children under age 21 in foster homes or private institutions for whom the Juvenile Justice Department is assuming full or partial financial responsibility are "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." These children also meet the non-IV-E foster care definition in M0310.115. When Juvenile Justice Department children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

A child also meets the non-IV-E foster care definition when placed by Juvenile Justice in the child's own home or a foster home if the child receives services from locally or regionally operated outreach detention programs which receive reimbursement from the Juvenile Justice Department.

Jails, learning centers, reception and diagnostic centers, and secure and less secure detention homes, even though they may have a capacity of 16 beds or less, are ineligible institutions and children housed therein are not eligible for Medicaid. Children temporarily sent to hospitals and/or psychiatric centers from a special placement in an ineligible institution with the intent to return to that ineligible institution are **not** eligible for Medicaid.

**3. Non IV-E Adoption Assistance**

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency."

Do not include non IV-E adoption assistance children who have "special medical needs" in this covered group. See M0320.308 below for special medical needs adoption assistance children.

**4. In ICF or ICF-MR**

Children under age 21 who are patients in nursing facilities meet this covered group. Children under age 21 who are patients in intermediate care facilities for the mentally retarded (ICF-MRs) also meet this covered group.

## C. Financial Eligibility

**1. Assistance Unit**

**a. Foster Care Children**

The child is a separate family unit of 1 person effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home, **unless** the child(ren) is placed in his own home.

Foster care children who are placed in their own homes with their parents and siblings are evaluated as an assistance unit according to chapter M05, except during trial visits for up to three months. A foster care child continues to be a single person unit during a trial visit. A "trial visit" is no longer than three months for this section's purposes.

If the unit's income and/or resources exceed the *F&C limits*, the child is not categorically needy non-money payment. If the unit's resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the foster care child and family members who meet an MN covered group are enrolled in Medicaid.

**b. Adoptive Placement**

Adoptive placement of a child who is in a public or private agency's custody does not always terminate the child's Medicaid eligibility. While in adoptive placement, the child meets the foster care definition and is an assistance unit of one person. Only the child's own income and resources are counted. The prospective adoptive parent's(s') income/resources are **not** counted or deemed available to the child until the entry of the interlocutory or final order of adoption, whichever comes first.

**c. Final Adoption and Non-IV-E Adoption Assistance**

Final adoption of any child, from either a public or private agency, terminates the child's Medicaid eligibility under the foster care definition. If the child receives an adoption assistance payment, or if the child was adopted under an adoption assistance agreement, then the child meets the "adoption assistance" definition.

Financial eligibility is determined using the assistance unit procedures in chapter M05, which require the inclusion of the child's adoptive parent(s). An adoption assistance child who is not a "special medical needs" child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's(s') income and resources available. If the child is adopted under a "special medical needs" adoption assistance agreement, see M0320.308 below. "Special medical needs" are defined in M0320.308 below.

**2. Asset Transfer** The asset transfer rules in subchapter M1450 must be met by the child.

**3. Resources** *There is no resource test for the Individuals Under Age 21 covered group.*

**4. Income** The income limits and requirements are found in chapter M07.

Adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

**D. Entitlement & Enrollment**

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The PD (program designation) for individuals in the CNNMP covered group of individuals under age 21 are:

- 76 for a non-IV-E foster care child;
- 72 for a non-IV-E adoption assistance child;
- 75 for a Juvenile Justice Department child;
- 82 for a child in nursing facility or ICF-MR.

## M0320.308 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

**A. Policy**

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the covered group of "special medical needs adoption assistance children."

**B. Nonfinancial Eligibility**

The child must

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

**C. Financial Eligibility**

**1. Assistance Unit**

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the adoption assistance child's own income and resources are counted.

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 must be met by the child.

**3. Resources**

*There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.*

**4. Income**

Adoption assistance children in residential facilities do not have a different income limit. The CNNMP income limit (F&C 100% income limit) for one person in the child's locality is used to determine eligibility as categorically needy non-money payment. For an adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the CNNMP income limit, evaluate the child in the medically needy covered group of "special medical needs adoption assistance" in subchapter M0330.

**D. Entitlement & Enrollment**

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The PD for individuals in the CNNMP covered group of special medical needs adoption assistance children is "72."

# M0320.309 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

**A. Policy**

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

**B. Nonfinancial Eligibility**

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020.

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Must be institutionalized in a medical institution, not an IMD;
8. Application to the Health Insurance Premium Payment Program (HIPP).

The individual must be a child under age 19, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-MR, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

**C. Financial Eligibility**

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

**1. Asset Transfer**

The individual must meet the asset transfer policy in subchapter M1450.

**2. Resources**

**a. Resource Eligibility - Married Individual**

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

**b. Resource Eligibility - Unmarried Individual**

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000. Pay close attention to

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

***3.* Income**

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 *and subchapter M1460*** **.** Determine what is income according to subchapter S0815, ABD What Is Not Income *and subchapter M1460, LTC Financial Eligibility*. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit *(see M810.002 A. 3.)*. If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the CNNMP covered group of F&C individuals in medical institutions.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, **re-calculate the individual's income** - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "62."

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is "60."

**E. Ineligible In This Covered Group**

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or *QI* if he/she has Medicare Part A.

## M0320.310 F&C RECEIVING WAIVER SERVICES (CBC)

**A. Policy**

42 CFR 435.217 - The State Plan includes the covered group of individuals who meet a families & children definition who live in the community, who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility care;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (*see M0810.002 A. 3.*).

**B. Nonfinancial Eligibility**

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets an F&C definition in M0310.

Verify receipt of Medicaid waiver services; use the procedures in chapter M14.

Do not wait until the individual starts to receive the waiver services to determine his/her eligibility in this covered group. Determine his/her

eligibility in this covered group if he/she is screened and approved to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that he/she will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

**C. Financial Eligibility**

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Resources**

**a. Resource Eligibility - Unmarried Individual**

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000. Pay close attention to

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

**c. Resource Eligibility - Married Individual**

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

**3. Income**

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 *and subchapter M1460*.** Determine what is income according to subchapter S0815, ABD What Is Not Income *and subchapter M1460, LTC Financial Eligibility*. DO NOT subtract the $20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit *(see* M0810.002 A. 3.). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

**D. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "62."

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is "60."

**E. Ineligible In This Covered Group**

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals,

redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

## M0320.311 F&C HOSPICE

**A. Policy**

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits.

In order to be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

*Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470).*

**B. Nonfinancial Eligibility**

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

The individual must elect hospice care. Election of hospice care is verified either *verbally* or in writing from the hospice. If the verification is *verbal,* document case record.

**C. Financial Eligibility**

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

**1. Asset Transfer**

*The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.*

**2. Resources**

**a. Resource Eligibility - Unmarried Individual**

When determining resources for an unmarried F&C hospice individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000.

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

**c. Resource Eligibility - Married Individual**

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

**3. Income**

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08.** Determine what is income according to subchapter S0815, ABD What Is Not Income. DO NOT subtract the $20 general exclusion or any other

income exclusions.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% SSI* income limit *(see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically indigent or medically needy.

**D. Entitlement & Enrollment**

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

**1. Entitlement**

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.205.

**2. Enrollment**

Enroll with program designation "54" for an individual who meets an F&C definition.

**E. Ineligible In This Covered Group**

There is no corresponding medically needy hospice covered group. Evaluate the individual in a medically indigent or medically needy covered group.

# M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

**A. Policy**

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services for certain women with breast and cervical cancer. Virginia has chosen to cover this group beginning July 1, 2001.

Women *eligible for the BCCPTA program must be age 40 through 64. They must have been screened and certified* as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program *and referred to LDSS for a Medicaid eligibility determination*. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer.

**B. Nonfinancial Eligibility**

**1. Required Nonfinancial Requirements**

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status;
- Virginia residency;
- social security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- SSI recipients.

**2. Creditable Health Insurance Coverage**

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance;
- a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.

**C. Financial Eligibility**

There are no Medicaid financial requirements for the BCCPTA covered group. The CDC Breast and Cervical Cancer Early Detection Program has income and resource requirements that are used to screen women for this program.

**D. Application Procedures**

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI pregnant women or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI pregnant women or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

**1. Application Form**

The BCCPTA Medicaid Application/Redetermination, form #032-03-384, was developed for this covered group only. The application includes the Breast and Cervical Cancer Early Detection Program certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. *Appendix 7 to subchapter M0120* contains a *sample* of the BCCPTA Medicaid Application/ Redetermination.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

**2. Application Processing Time Frames**

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

**3. Notices**

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

***E.* Entitlement**

**1. Entitlement Beg Date**

Medicaid eligibility in the BCCPTA covered group can begin no earlier than July 1, 2001. *Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.*

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, but no earlier than July 1, 2001.

**2. Retroactive Entitlement**

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the CDC *Breast and Cervical Cancer Early Detection Program* and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s*)*. However, coverage can begin no earlier than July 1, 2001.

**F. Enrollment**

The PD for BCCPTA women is "66".

***G. Redetermination***

*Annual redetermination requirements are applicable to the BCCPTA covered group. Section 3 on the BCCPTA Application/Redetermination, form is not applicable at redetermination. At the time of the annual redetermination, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer.*

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

# Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application/Redetermination

**AGENCY USE ONLY**

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: | WORKER

**Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.**

## 1. IDENTIFYING INFORMATION

LAST NAME: | FIRST NAME: | MI: | SOCIAL SECURITY NUMBER:

ADDRESS: | CITY: | STATE: | ZIP: | STATE OF RESIDENCE:

MAILING ADDRESS (If different): | CITY: | STATE: | ZIP: | HOME PHONE #: | DAYTIME PHONE #:

## 2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH:

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER:

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME:

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE:

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS:

## 3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER : _____ DATE: _____

032-03-384/1

## YOUR RIGHTS AND RESPONSIBILITIES

**By signing below, I agree to the following:**

**I have the right to:**

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

**I have the responsibility to:**

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

**I further understand and agree that:**

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____

**Signature or Mark** **Date**

_____ _____

**Witness/Authorized Representative** **Date**

**VOTER REGISTRATION**

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

**BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA) MEDICAID APPLICATION/REDETERMINATION**

**FORM NUMBER - 032-03-384**

**PURPOSE OF FORM -** This form is the Medicaid application/redetermination form for women who have been screened and diagnosed with breast or cervical cancer under the CDC BCCEDP and are in need of treatment.

**USE OF THE FORM -** This form is used to collect the information needed to determine Medicaid eligibility in the BCCPTA covered group and enroll the eligible woman in the MMIS.

**NUMBER OF COPIES** - Original.

**DISPOSITION OF FORM -** The original is filed in the case record.

**INSTRUCTIONS FOR PREPARATION OF THE FORM**

Section 1: Section 1 is used to collect identifying information for the applicant/recipient.

Section 2: Section 2 is used to obtain the nonfinancial information used to determine eligibility in the BCCPTA covered group.

Section 3: Section 3 is the certification that the woman is a BCCEDP participant and is eligible for Medicaid under the BCCPTA. This certification must be signed by a provider or certifying individual under the authority of the CDC BCCEDP.

The rights and responsibilities and voter registration are on the reverse side of the form.

# CHAPTER M03
# MEDICAID COVERED GROUPS
# SUBCHAPTER 30

# MEDICALLY NEEDY GROUPS

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## M03 MEDICAID COVERED GROUPS

## M0330.000 MEDICALLY NEEDY GROUPS

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# M0330.001 GENERAL POLICY PRINCIPLES

**A. Introduction**

All medically needy covered groups are optional; the federal Medicaid law does not require the state to cover the medically needy groups in its Medicaid state plan. However, if a state chooses to cover the medically needy, the state plan must cover all pregnant women, newborn children and individuals under age 18 who, except for resources and income, would be eligible for Medicaid as categorically needy. There are fewer MN covered groups than categorically needy covered groups.

Virginia chose to cover the medically needy. In addition to the required medically needy covered groups, Virginia chose to cover aged, blind, and disabled individuals and reasonable classifications of individuals under age 21.

**1. MN Individual**

The medically needy individual does not meet the financial requirements for a money payment, but has insufficient income and resources to meet his medical care needs. A medically needy individual is an individual who

- meets all the non-financial eligibility requirements in Chapter M02,
- meets one of the definitions in M0310 and an MN covered group,
- meets the appropriate MN resource and income requirements,
- is not an ineligible person listed in M0210.100, and
- does not meet a CN or CNNMP covered group.

**2. Spenddown Feature**

The major feature of the MN covered groups is a spenddown. An individual who meets the nonfinancial and MN resource eligibility requirements but whose income exceeds the MN income limit may a "spenddown" the excess income by deducting incurred medical expenses and become eligible for a limited period of full medically needy Medicaid coverage. An individual who has excess income becomes eligible when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit.

**3. Different Benefit Package**

Some medical services that are covered for the categorically needy covered groups are not available to the medically needy. ICF-MR services and IMD services are not covered for medically needy eligible recipients. However, the basic services such as inpatient and outpatient hospital, physicians, X-rays, prescription drugs, home health services and Medicare premiums, coinsurance and deductibles are covered for the medically needy. Long-term care nursing facility and waiver services are also covered for the medically needy.

**B. Procedure**

This subchapter explains in detail each of the MN covered groups and how to determine if an individual meets the requirements of an MN covered group. The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid medically needy covered group:

- M0330.200 ABD Medically Needy Groups;
- M0330.201 Aged Individuals;
- M0330.202 Blind Individuals;
- M0330.203 Disabled Individuals;
- M0330.204 December 1973 Eligibles;
- M0330.300 Families & Children Medically Needy Groups;
- M0330.301 Pregnant Women;
- M0330.302 Newborn Children Under Age 1;
- M0330.303 Children Under Age 18;
- M0330.304 Individuals Under Age 21;
- M0330.305 Special Medical Needs Adoption Assistance.

## M0330.200 ABD MEDICALLY NEEDY GROUPS

**A. Introduction**

To be eligible in an ABD (aged, blind or disabled) covered group, the individual must first meet the "Aged," "Blind" or "Disabled" definition in section M0310.100. If he/she does not meet the aged, blind or disabled definition, then go to Families & Children Medically Needy covered groups in section M0330.300 below.

**B. Procedure**

The policy and procedures for determining whether an individual meets an ABD MN covered group are contained in the following sections:

- M0330.201 Aged Individuals;
- M0330.202 Blind Individual;
- M0330.203 Disabled Individuals;
- M0330.204 December 1973 Eligibles.

**1. Individual Not ABD Eligible Due To Home Property**

If the individual is not eligible in an ABD covered group because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

**2. Individual Ineligible Due To Excess Resources**

If the individual is not eligible in an ABD covered group because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. If the individual is eligible as ABD MI, he/she will not be entitled to the full Medicaid benefit package; Medicaid will only pay the individual's Medicare premiums only, or the Medicare premiums, deductibles and coinsurance amounts. Other Medicaid covered services

such as prescription drugs and long-term care are not covered for the ABD MI.

## M0330.201 AGED INDIVIDUALS

**A. Nonfinancial Eligibility**

42 CFR 435.330 - An individual is eligible in this covered group if he/she has attained age 65 years (M0310.105) and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

**B. Financial Eligibility**

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Assistance Unit**

The assistance unit policy and procedures in chapter M05 apply to aged medically needy individuals. If *married and* not institutionalized, deem or count any resources and income from the individual's spouse with whom he/she lives. If *married and* institutionalized, *go* to *subchapter M1480 for* resource and income determination policy and procedures.

**3. Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in *subchapter M1480*.

**a. Resources Within The Limit**

If current resources are within the limit, go on to determine income eligibility.

**b. Resources Exceed The Limit**

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children (F&C) definition, determine if the individual meets an F&C covered group since the F&C home property definition is more liberal for F&C.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group since the MI ABD resource requirements are more liberal than the MN requirements. See sections M0320.206, 207, *and 208* for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

**4. Income**

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

**5. Income Exceeds MN Limit**

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group since the MI ABD income limits are higher than the MN limits. *See sections M0320.206, 207, and 208 for the ABD MI covered groups.*

## C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

## D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

**1. Program Designations**

**a. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**28**."

**b. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income

over the QMB income limit - enroll the individual with program designation "**18."**

**2. Recipient's PD Changes To QMB-only**

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only PD effective the first day of the month immediately following the cancellation date.

**3. QMB Meets Spenddown**

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is aged MN dual-eligible QMB – "**28."**

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

**4. Spenddown Period Ends**

**a. Not QMB Eligible**

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

**b. QMB Eligible**

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

## M0330.202 BLIND INDIVIDUALS

**A. Nonfinancial Eligibility**

42 CFR 435.330 - An individual is eligible in this covered group if he/she is blind according to the definition in M0310.106 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;

5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

**B. Financial Eligibility**

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Assistance Unit**

The assistance unit policy and procedures in chapter M05 apply to blind medically needy individuals. If not institutionalized, deem any resources and income from the individual's spouse with whom he/she lives, and his/her parent(s), if individual is under age 21, with whom he/she lives.

**3. Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in *subchapter M1480*.

**a. Resources Within The Limit**

If current resources are within the limit, go on to determine income eligibility.

**b. Resources Exceed The Limit**

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See M0320.206 through 208 for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

**4. Income**

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Note the special earned income exclusions for blind individuals.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

**5. Income Exceeds MN Limit**

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD income limits are higher than the MN limits. See sections M0320.206 through 208 for the ABD MI covered groups.

**C. Entitlement**

Eligible individuals in this MN group are entitled to full medically needy Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

**D. Enrollment**

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

**1. Program Designations**

**a. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**48**."

**b. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - enroll the individual with program designation "**38."**

**2. Recipient's PD Changes To QMB-only**

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only PD effective the first day of the month immediately following the cancellation date.

**3. QMB Meets Spenddown**

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is blind MN dual-eligible QMB "**48.**"

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

**4. Spenddown Period Ends**

**a. Not QMB Eligible**

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

**b. QMB Eligible**

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

## M0330.203 DISABLED INDIVIDUALS

**A. Nonfinancial Eligibility**

42 CFR 435.330 - An individual is eligible in this covered group if he/she meets the disabled definition in M0310.112 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

**B. Financial Eligibility**

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Assistance Unit**

The assistance unit policy and procedures in chapter M05 apply to disabled medically needy individuals. If not institutionalized, deem any

resources and income from the individual's spouse with whom he/she lives, and from the individual's parent(s), if individual is under age 21, with whom he/she lives.

**3. Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in *subchapter M1480.*

**a. Resources Within The Limit**

If current resources are within the limit, go on to determine income eligibility.

**b. Resources Exceed The Limit**

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See sections M0320.206 through 208 for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

**4. Income**

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Note the special earned income exclusions for disabled individuals.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

**5. Income Exceeds MN Limit**

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because

the MI ABD income limits are higher than the MN limits. See sections M0320.206 through 208 for the ABD MI covered groups.

**C. Entitlement**

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

**D. Enrollment**

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

**1. Program Designations**

**a. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**68**."

**b. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - enroll the individual with program designation "**58."**

**2. Recipient's PD Changes To QMB**

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only PD effective the first day of the month immediately following the cancellation date.

**3. QMB Meets Spenddown**

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is the aged MN dual-eligible QMB "**68."**

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

**4. Spenddown Period Ends**

**a. Not QMB Eligible**

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

**b. QMB Eligible**

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

## M0330.204 DECEMBER 1973 ELIGIBLES

**A. Policy**

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973. This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

**B. December 1973 Eligibility Requirements**

**1. Nonfinancial**

a. The individual must meet the nonfinancial eligibility requirements:

- Citizenship/alien status (M0220);
- Virginia residency (M0230);
- Social security number provision/application requirements (M0240);
- Cooperation in pursuing support (*M0250)*;
- Application for other benefits (M0270);
- Institutional status requirements (M0280).

b. It is not necessary to re-establish the blindness or disability requirement unless:

- the decision of the APTD Review Team or the Commission for the Visually Handicapped ophthalmologist was for a limited period, or

- the local department of social services has reason to believe the physical impairment or the visual handicap has been overcome or substantially improved.

If one of the above conditions exists, contact the Medicaid Disability Unit of the Department of Rehabilitative Services or the Department for the Visually Handicapped, as appropriate by the usual method to redetermine the individual's eligibility using the criteria followed by the former APTD Review Team or Commission for the Visually Handicapped in December, 1973.

**2. Assistance Unit**

The assistance unit consists of the blind or disabled individual, his or her spouse, and the blind or disabled individual's children under age 18 who live in the home. It also includes other specified individuals who are considered essential to his/her (or their) well-being (EWB).

**3. Persons Essential To Well-Being (EWB)**

Certain individuals are included in the blind or disabled individual's assistance unit if the following conditions are met:

a. the EWB person does not meet a Medicaid ABD or F&C definition.

b. the EWB person is living in the same household with the blind or disabled individual.

c. the EWB person is either

- a relative of specified degree (spouse, parent, grandparent, child, grandchild or sibling, except when the relative is age 16 years or older, is employable and out of school unless he is performing essential services which preclude his employment), or

- is performing a service for the individual that contributes to the security and physical, mental or social well-being of the individual and which otherwise would have to be purchased;

d. the EWB person is in need, i.e. has resources and income insufficient to meet his total allowable individual requirements, based on the resource and income limit for one person.

e. the EWB person wants his/her needs and resources and income considered in determining the blind or disabled individual's eligibility.

**4. Resources**

**a. Resource Limits**

Total resources (real and personal property) may not exceed $600 for a single person, $900 for two persons and $100 for each additional person in the family unit.

**b. Home Property**

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility. A home is considered to be the house and lot or adjacent land, including a garden and outbuildings used in connection with the dwelling. It does not include land and outbuildings used for farming purposes.

**c. Income-Producing Real Property**

Ownership of income-producing real property, other than the home, such as may be used for farming or business, precludes eligibility if the equity therein of a family unit is $10,000 or more. Real property cannot be considered income-producing unless there is a reasonable annual income of approximately 10% of the market value of the property or gross income comparable to that received from similar property located in the community.

**d. Other Real Property**

Ownership of any other real property precludes eligibility unless the property cannot be sold, or sale would involve undue monetary sacrifice, or unless the market value of the property, if added to the personal property, does not exceed the allowable amount of personal property.

**e. Personal Property**

Personal property includes bank accounts, bonds, and other cash liquidable assets, and nonliquidable assets such as motor vehicles, stocks, cash value of life insurance.

When evaluating personal property, exclude

- life insurance policies with total face value of $5,000 or less for an individual,
- household equipment and furnishings,
- one motor vehicle,
- livestock providing food for family consumption
- farming or business equipment or livestock which are income-producing.

Life Insurance - When insurance (life, retirement, and other related types) has a total face value of over $5,000 for an individual, ascertain the cash value and count it as a resource. If, however, income benefits such as disability payments are currently available under the provisions

of a policy, the case surrender value of such policy does not necessarily have to be counted as a resource, if it is in the best interest of the client and the agency for the provisions of the policy to remain unchanged.

**5. Income**

**a. Income Limits**

The **annual** income limits were $1,900 for one person and $2,500 for two persons, and $400 for each additional person in the assistance unit. Monthly limits: $158.33 for 1 person; $208.33 for 2 persons; $33.33 monthly for each additional person ($241.66 for 3 persons; $274.99 for 4 persons, etc.).

**b. Unearned Income**

Social Security and Railroad Retirement benefits - For OAA and APTD-related persons who receive Social Security or Railroad Retirement benefits the first $4.00 monthly of such benefits for each recipient is excluded EXCEPT for the individual who is in a nursing facility and now receives $30.00 a month clothing and personal care allowance from SSI. Do not exclude $4.00 of the SSA or RR benefit received by an individual in a medical facility who now receives a $30 SSI check.

This exclusion is **not** applicable to the ineligible spouse who does not meet a Medicaid covered group.

**c. Earned Income Exclusion for OAA and APTD-related Persons**

The earned income exclusion for OAA and APTD-related individuals is the first $20 a month plus 1/2 the remainder up to a maximum of $35 per month.

**C. Does Not Meet 1973 Requirements**

If the individual no longer meets the December 1973 nonfinancial or financial eligibility requirements, the individual is not eligible in this MN covered group. Determine his/her eligibility in another covered group.

**D. Meets 1973 Requirements**

If the individual meets the December 1973 nonfinancial and financial eligibility requirements, the individual also meets the current medically needy resource and income requirements, except for life insurance. The current medically needy life insurance requirement is more restrictive than the 1973 requirement.

If the individual has life insurance, redetermine the life insurance countable value. Total all countable resources and compare the total to the current medically needy resource limit. If countable resources are within the current limit, the individual is eligible in this MN covered group.

**E. Entitlement & Enrollment**

Eligible individuals in this group are entitled to full Medicaid coverage.

Eligible individuals in this group are classified as medically needy (MN).

**1. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A - his income is within the QMB income limit. Program designations:

- 48 for blind MN dual-eligible QMB;
- 68 for disabled MN dual-eligible QMB.

**2. Not QMB**

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A - the program designation is:

- 38 for blind MN not QMB;
- 58 for disabled MN not QMB.

## M0330.300 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

**A. Introduction**

An F&C medically needy individual must

- be a child under age 18, or
- meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.

**B. Procedure**

The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:

- M0330.301 Pregnant Women;
- M0330.302 Newborn Children Under Age 1;
- M0330.303 Children Under Age 18;
- M0320.304 Individuals Under Age 21;
- M0320.305 Special Medical Needs Adoption Assistance.

**C. Individual Ineligible Due To Excess Resources or Income**

If the individual is not eligible in an F&C covered group because of excess resources or income and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because some of the MI ABD resource and income requirements are more liberal than the F&C MN resource requirements (motor vehicle, other real property occupied by dependent relative, unearned income exclusion, earned income exclusions).

If the individual is eligible as ABD MI, he/she will not be entitled to the full Medicaid benefit package; Medicaid will only pay the individual's Medicare premiums or the individual's Medicare premiums, deductibles and coinsurance amounts. Other Medicaid covered services such as prescription drugs and long-term care are not covered for the ABD MI.

# M0330.301 PREGNANT WOMEN

**A. Nonfinancial Eligibility**

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

**A pregnant woman's Medicaid eligibility is first determined in the MI pregnant women covered group** which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as MI because her income is too high, then she may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
   NOTE: an MN pregnant woman must cooperate in pursuing support; see subchapter M0250);
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

**B. Financial Eligibility**

**1. Asset Transfer**

The individual must meet the asset transfer policy in *subchapter* M1450.

**2. Assistance Unit**

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) classification and covered group(s).

**3. Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

**a. Resources Within The Limit**

If current resources are within the limit, go on to determine income eligibility.

**b. Resources Exceed The Limit**

If *current resources exceed the limit, she is not eligible in this covered group.*

**4. Income**

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

***5.* Income Exceeds MN Limit**

Because the MN pregnant woman's income exceeds the MI limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

***6.* Income Changes**

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements.

*The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.*

**C. Entitlement**

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met, and ending the last day of the month in which the 60th day occurs or the spenddown period ends, whichever comes first. Retroactive coverage is applicable to this covered group.

**EXAMPLE:**

*A pregnant woman living in Group III applied for Medicaid on March 3. Her estimated date of conception is January 24, and her due date is October 20. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period March 1 through August 31. She meets the spenddown on May 11 and is enrolled in Medicaid as a medically needy pregnant woman through August 31.*

*She reapplies for Medicaid on September 5. Her income increased in August. Because her income increased after she established eligibility, but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility. Her income that was verified in March is used to calculate her spenddown. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and she establishes eligibility. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day occurred after her pregnancy ended. She no longer meets the pregnant woman covered group requirements.*

*Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the coverage.*

**D. Enrollment**

Eligible individuals in this group are classified as medically needy (MN), program designation "**97**."

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# M0330.302 NEWBORN CHILDREN UNDER AGE 1

**A. Policy**

42 CFR 435.301 (b)(1)(iii) - If the state chooses to cover the MN, the State Plan must provide MN coverage to all newborn children born on or after October 1, 1984 to a woman who is eligible as MN and is receiving Medicaid on the date of the child's birth. *Coverage must be provided to those newborn children whose mothers were eligible as MN but whose coverage was restricted to Medicaid payment for labor and delivery as an emergency service.* The child remains eligible for one year so long as the child is a member of the mother's household and the mother

- remains eligible in any Medicaid covered group, or
- would be eligible for Medicaid if she were pregnant.

The mother is considered to remain eligible if she meets the spenddown requirements in any consecutive spenddown budget period following the birth of the child.

**B. Nonfinancial Eligibility**

A child who meets this covered group:

- is under age of 1 year;
- was born to a mother who is found eligible for Medicaid as medically needy or meets spenddown effective on or before the date of the child's birth; and
- lives with his/her mother.

**1. Continued Eligibility When Mother Becomes Ineligible**

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1** even though his/her mother loses her eligibility, as long as the following conditions are met:

- the child remains in the home with the mother, and
- the mother would be eligible for Medicaid as medically needy if she were still pregnant.

**EXAMPLE #*4*:** A pregnant woman living in Group III applied for Medicaid on October 24, 1997. Her estimated date of conception is March 24, 1997, and her due date is December 20, 1997. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, 1997 through March 31, 1998. She meets the spenddown on November 15, 1997, and is enrolled in Medicaid as MN effective November 15, 1997 through March 31, 1998.

Her child is born on November 30, 1997, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, 1998, the last day of the month in which the 60th day

occurred after her pregnancy ended. The newborn's Medicaid coverage continues through the end of the spenddown period because the child's mother would be eligible for Medicaid during that time if she were pregnant *(there was no change in her income)*. The child's Medicaid coverage is canceled at the end of the spenddown period, 3-31-98, because the child's mother would NOT be eligible for Medicaid after 3-31-98 even if she were pregnant.

**2. Covered Group Eligibility Ends**

The child no longer meets this covered group effective:

a. the end of the month during which the child ceases to live with the mother;

b. the end of the month in which the child reaches age 1 year; or

c. the end of the month in which the mother no longer meets one of the following nonfinancial requirements (she would be **ineligible** even if she were pregnant):

- Citizenship/alien status (M0220);
- Virginia residency (M0230);
- Social security number provision/application requirements (M0240);
- Assignment of rights to medical benefits requirements (M0250);
- Cooperation in pursuing support *(M0250);*
- Application for other benefits (M0270);
- Institutional status requirements (M0280);
- Application to the Health Insurance Premium Payment Program (HIPP) (M0290).

d. effective the end of the spenddown period.

**B. Financial Eligibility**

No other nonfinancial or financial eligibility requirements need to be met by the child.

**C. Entitlement & Enrollment**

Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth.

Eligible children in this group are classified as medically needy (MN), program designation "**99**."

## M0330.303 CHILDREN UNDER AGE 18

**. Nonfinancial Eligibility**

42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.

A child under age 18's Medicaid eligibility is first determined in the categorically needy *MI Child UnderAge 19* covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a child under age 18 is not eligible as MI because the child's countable income is too high, then the child may spenddown to the lower MN income limit **IF** the child's resources are within the MN resource limit.

A child is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;
8. Application to the Health Insurance Premium Payment Program (HIPP).

**B. Financial Eligibility**

**1. Asset Transfer**

The child must meet the asset transfer policy in *subchapter* M1450.

**2. Assistance Unit**

The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

**3. Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the child is married and institutionalized, use the resource policy in *subchapter M1480.*

**a. Resources Within The Limit**

If the child's resources are within the MN limit, go on to determine income eligibility.

**b. Resources Exceed The Limit**

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

**4. Income**

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the child's locality group (see section M0710, Appendix 5 for the MN income limits).

**5. Income Exceeds MN Limit**

Because the MI children income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

**C. Entitlement & Enrollment**

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Eligible children in this group are classified as medically needy (MN), program designation "**88**."

## M0330.304 INDIVIDUALS UNDER AGE 21

**A. Policy**

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who would not be eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- individuals in foster homes, private institutions, *or independent living arrangements* for whom a public agency is assuming full or partial financial responsibility; *NOTE: a foster care child in a non-custodial agreement who is in an independent living situation meets this requirement and is eligible in this covered group;*
- individuals placed in foster homes, private institutions *or independent living arrangements* by private nonprofit child placing agencies;
- individuals in adoptions subsidized in full or in part by a public agency;
- individuals in nursing facilities;
- individual in intermediate care facilities for the mentally retarded (ICF-MRs). NOTE: the ICF-MR services are not covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF-MRs.

**B. Nonfinancial Eligibility**

The child must be under age 21 and must meet the nonfinancial requirements in chapter M02.

**1. Non IV-E Foster Care**

Children who meet the foster care definition in M310.112, but who are not IV-E eligible, are non IV-E "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

A non IV-E foster care child also meets this definition when placed by the agency in the child's own home for a "trial" period of three months if the child continues to be in the agency's custody.

**2. Juvenile Justice Department Children**

Children under age 21 in foster homes or private institutions for whom the Juvenile Justice Department is assuming full or partial financial responsibility are "individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility." These children also meet the foster care definition in M0310.112. When Juvenile Justice Department children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

A child also meets this definition when placed by Juvenile Justice in the child's own home or a foster home if the child receives services from locally or regionally operated outreach detention programs which receive reimbursement from the Juvenile Justice Department.

Jails, learning centers, reception and diagnostic centers, and secure and less secure detention homes, even though they may have a capacity of 16 beds or less, are ineligible institutions and children housed therein are not eligible for Medicaid. Children temporarily sent to hospitals and/or psychiatric centers from a special placement in an ineligible institution with the intent to return to that ineligible institution are not eligible for Medicaid.

**3. Non IV-E Adoption Assistance**

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a non-IVE adoption assistance agreement between the local Department of Social Services (DSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." These children do NOT include "special medical needs children." See section M0330.305 below for special medical needs children.

**4. In ICF or ICF-MR**

Children under age 21 who are patients in nursing facilities meet this covered group. Children under age 21 who are patients in intermediate care facilities for the mentally retarded (ICF-MRs) also meet this covered group.

## C. Financial Eligibility

**1. Assistance Unit**

**a. Foster Care Children**

Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home, **unless** the child(ren) is placed in his own home. Foster care children who are placed in their own homes with their parents and siblings are evaluated as an assistance unit according to chapter M05, except during trial visits for up to three months. A foster care child continues to be a single person unit during a trial visit. A "trial visit" is no longer than three months for this section's purposes.

**b. Adoptive Placement**

Adoptive placement of a child who is in a public or private agency's custody does not always terminate the child's Medicaid eligibility. While in adoptive placement, the child meets the foster care definition and is an assistance unit of one person. Only the child's own income and resources are counted. The prospective adoptive parent's(s) income/resources are not counted or deemed available to the child until the entry of the interlocutory or final order of adoption, whichever comes first.

**c. Final Adoption and Non-IV-E Adoption Assistance**

Final adoption of any child, from either a public or private agency, terminates the child's Medicaid eligibility under the foster care definition. If the child receives an adoption assistance payment, or if the child was adopted under an adoption assistance agreement, then the child meets the "adoption assistance" definition. Financial eligibility of an adoption assistance child is determined using the assistance unit procedures in chapter M05, which require the inclusion of the child's adoptive parent(s), unless the child is adopted under a "special medical needs" adoption assistance agreement.

**d. Special Medical Needs Adoption Assistance**

"Special medical needs" are defined in, and the policy and procedures for special medical needs adoption assistance children are contained in, section M0330.305 below.

**2. Resources**

The resource limit and requirements are found in chapter M06.

If the resources exceed the MN limit, the child is not eligible for Medicaid as medically needy. If the child is under age 19, determine his/her eligibility in the *MI Child Under Age 19* covered group.

**3. Income**

The income limits and requirements are found in chapter M07.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

If the unit's income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the foster

care/adoption assistance child and family members who meet a Medicaid covered group are enrolled in Medicaid.

**D. Entitlement & Enrollment**

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The PD (program designation) for individuals in this covered group are:

- 86 for a non-IVE foster care or non-IVE adoption assistance child;
- 85 for a Juvenile Justice Department child;
- 98 for a child under age 21 in nursing facility or ICF-MR.

## M0330.305 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE

**A. Policy**

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;

- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and

- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the MN covered group of "special medical needs adoption assistance children."

**B. Nonfinancial Eligibility**

The child must

- be under age 21,

- meet the "special medical needs" adoption assistance definition in M0310.102, and

- meet the nonfinancial requirements in chapter M02.

**C. Financial Eligibility**

**1. Assistance Unit**

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the adoption assistance child's own income and resources are counted.

**2. Asset Transfer**

The asset transfer rules in *subchapter* M1450 must be met by the child.

**3. Resources**

The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child's eligibility as F&C medically indigent because that classification has no resource limits.

**4. Income**

Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child's locality is used to determine the child's MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child's medical expenses are used to meet the spenddown. Once the spenddown is met, the special medical needs adoption assistance child is enrolled in Medicaid.

**D. Entitlement & Enrollment**

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

The PD (program designation) for individuals in the MN covered group of special medical needs adoption assistance children is "**86.**"